			For State Registrar	• •		/ Depa		lealth an	d Mental Hy		•	16001
S. C.	Physici /Medic		1. Decedent's Name (First, Middle, Last) Nancy Cole		m				2. Date of D Month May	Day	2006 Year	3. Time of Death 1:30 p M
	Examin		4a. Facility Name (If not institution, give s 1685 Harvey Yingli 5. Social Security Number 6. Sex	ng Road	e (In yrs. last	hirthday	4b. City, Town, or Manche If Under 1 Year				County of Death	11
	Funeral Director	l i	-		65	Yrs.	Months Days		Jan 17	av. Year)	1 Mar	place (State or Foreign intry) yland
:	ne Marylan 8a-f show	ector	Maryland Carro	11	10c. City, T	own or Lo	М	anchest	ter			10d. Inside City Limits 1 ☐ Yes 🏖 No
	with the	Dic	10e. Street and Number 1685 Harvey Yingl:	ing Road			10f. Zip Code	21102		10g. Citi:	zen of What Co. USA	intry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if tien 27 is marked other than "natural", or items 23a or 28a-f show sny injury or other traumatic event, the Medical Examinar must be notified at page.	by Funeral Director		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2√2 No		? (Specify Yes or Nuerto Rican, etc.)		14. Race - Amer Black, White	
Maryland 21215-0036	within 72 ho jiene. r than "natur tha Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	cation completed) College (1-4or 5	5+)		dent's Usual Occup. kind of work done of DO NDT use retired ecretary	ation during most of l)	working		nd of Business/l	Company
yland	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) George Itnyre						Name (First, Middl ise Paugh		Sumame)	
, Mar	and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship (Type Raymond D. Bloom,		and	1685	Harvey Y	/inglin	r Rural Route Num. g Rd, Mar	chest	ter, MD	21102
Baltimore,	. Pages 1 tment of H tent: if ite jury or ot		20a. Method of Disposition ★☐ Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)		1	dow B	esition (Name of matory or other place ranch Cen	n. 05	/10/2006	Wes	cation - City or 1 stminste	er, MD
Bai	Departiment Departiment Important Im		21. Signature of Funeral Service License Waniel Of	Marks	00443			s Stree	Myers-Du t, Westmi	inste		1157
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on the time of the cause (Final disease or condition resulting in death) Sequentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as	a consequen	Me nce of):	Alexander dyn	Such as car	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Exar	that initiated events resulting in death) Last	Due to (or as 3c. If yes, outcome 1 \(\triangle \trian	of pregnancy	y path 3	Ectopic pregnancy			2	23d. Date of delin	very Day Year
ds, P.O.	w requires that the been signed by th should be detache	þ	9 □ Unknown Part II. Other significant conditions con Two T	9 Unknown	ut not sesulty	ng in the u	nderlying cause give	en in Part I.		tobacco u	Q.	the cause of death?
		Completed	J(************************************						per	s an opsy formed?	prior to c death?	copsy findings available ompletion of cause of
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:			oth Oth	or.	Death Check only			
ō	Attending Physrdeath. cotor: After this by the funeral di	atlon: To	1 Yes 20 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatie 28a. Date of Inju (Month, Da	ıry 28	VOutpatier Bb. Time o Injury	f 28c. Injun	4 Nursir	28d. Describe			ify)
Divis	in Diffe	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home c. (Specify)	e, farm, str	reet, factory, office		28f. Location City or To	(Street and own, State)	d Number or Ru)	ral Route Number,
	the Hospitai in 24 hours a the Funerai ipletely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best ner: On the basis of and manner sta	f examination	ndge, death n and/or in	vestigation, in my o	ne date and pl pinion, death o	lana, and due to the occurred at the time	nauss(s) , date and	and harner an place, and due	to the cause(s)
	To the Complete	Σ	29b. Signature and title of certifier	La			29c. Licens	6/12			signed (Month	-
	ंग		30. Name and address of person who co Dr. Alexander Roch		· ·			Hamneto	ad Mn o	1074		
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 8 2	32. Registr	ar's Signature	0	forte		III 2			

				States Malskan	leirDapa Cei	tificate of	912/07di Death			0.6	16002
г	Physici	an	1. Decedent's Name (First, Middle, Last)	100				2. Date of Dea Month	Day	Year	18.36p
100	/Medic	al	Quinnie Olivia Bai 4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Deati	124 h	29 d	of Death	1031
	Examin	ier	Pennsula Regional		MU		usby		1/	mico	
	Funeral Director		Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April 1	, Year)	9. Birthpli Count M	• •
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation			· · · · · · · · · · · · · · · · · · ·	10	d. Inside City Limits
	Maryla 1 eho ied a	ō	MD	Ba	ltimo	re					1X Yes 2 No
	r 28e	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Count	ry?
	h with	a D	5506 Haddon Avenue			21207				USA	
980	72 hours after death with the Maryland Intelligent tems 23s or 28e-f ehow idical Examinations to notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes ≥ ∑XNo If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (S an, Mexican, Puerl Specify:	Specify Yes or No- to Rican, etc.)	Blad	e · America ck, White, e y: Blac	tc.
21215-0036	within 72 ho jiene. r then "neture the Madical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	pation during most of world)	rking	16b. Kind of B	usiness/Ind	ustry
d 2	filed v Hygie other t	e Co	n/a 17. Father's Name (First, Middle, Last)			n/a	18. Mother's Nar	me (First, Middle,		-	
lan	ould be Mentel narked c	To B	Jannis M. Bailey				Catheri	ne Bessi	x Baile	У	
Maryland	£ 5 E E	-	19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailin	ng Address (Street	and Number or Ru	ural Route Numbe	r, City or Town,	State, Zip	Code)
	999 T		Catherine M. Baile			Haddon A	ve., Bal				
Baltimore,			20a. Method of Disposition 1	emoval from State	metery, crei	sition (Name of natory or other plac		Date	20c. Location -		
ij	rtmen rtent: njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			res Mem P		0/2006	Salisb	ury,	MD 21801
Bal	permit. Page Depertment of Importent: If eny injury or		* Talana DU	tatson	La 1	ewis N. W 518 West	latson Fu Rd., Sal	isbury,	MD 2180	1	
Н			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death ie cause on each line.	. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory an	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	~	latu	2 801	lepti	Wo			
	Examiner		ſ	Due to (or as a consequ	ence of):	ecvo	1	,			
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P.O. Box 6	The law requires that the death certificate has been signed by the ettending I page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3[Ectopic pregnancy Other (specify)	У			te of deliver	y Day Year
	w requires that been signed by should be deta	ρ	Part II. Other significant conditions cor	stributing to death but not resu	liting in the u	nderlying cause giv	ven in Part I.			tribute to the	e cause of death?
Il Records,		Completed							rmed?	Were autop prior to con death? 1 Yes	osy findings available apletion of cause of
Vital	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		ot ook Ot		ath Check only o			
o	Phys ral dii	. To	1 Yes 2 No	1 Ir Inpatient 2 ☐ I 28a. Date of Injury (Month, Day Year)	ER/Outpaties 28b. Time o	IL SEL DOX	4 Ivuising r	Home 5 ☐ Resid)
ion	Attending Phy r death. ector: After thi by the funeral of	ation	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? Yes 2∐No				
Division	f or Attendl after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	reet, factory, office		28f. Location (S City or Tow		er or Rural	Route Number,
_	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, deat ion and/or in	h occurred at the ti vestigation, in my o	me, date and place opinion, death occu	e, and due to the ourred at the time, o	cause(s) and madate and place,	anner as sta and due to	ated. the cause(s)
	within To th	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe		-
	20		Komm	- mo		9	16182	7-	4/0	9/01	6
	M		30. Name and address of person who co	in a ser par	11/1	- AL	ISBUM	NO			
-	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 8 2	32. Registrar's Signa	ture	Carles					

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Please Type or Print in Black Indelible Ink

Villlard Percy B	Brow	n State of Maryland / 1- For State Registrar		artment of tificate of		d Menta	al Hyg		g. No. 20	106 !500
Physici Medical Exam		Decedent's Name (First, Middle, Last) Willard Percy Br	rown					Date of Death Month May 2, 200	n Dav Year	3. Time of Death 0430 hrs
		4a. Facility Name (if not institution, give street and number) 1507 Nichole Rd.			b. City, Town, or Waldorf	Location of I			4c. County of Charles	Death
Funeral Director		579-36-8695 1XM 2_F		ast birthday) 74 Yrs.	If Under 1 Year Months Days		24Hrs. 8 Min.		/1931	9 Birthplace (State or Foreign Country) Virginia
v any			Oc. City,	Town or Locati	on					10d. Inside City Limits
Aaryland 28a-f show any <u>1 at once.</u>	ctor	Maryland Charles 10e. Street and Number		Waldor	f 10f. Zip Code			Lio	g. Citizen of What	1 Yes 2XX No
ith the Maryland 23a or 28a-f sho notified at once	Director	1507 Nicholas Road			20601				-	S.A.
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 X Married 1 Never Married 2 X Married 1 X Yes 2 3 Widowed 4 Divorced of Dates:	ver in U.S	lf Ye	S Decedent of Hispes, specify Cuban, Yes 2 X No	Mexican, P	? (Specii uerto Ric	fy Yes or No- an, etc.)	14. Race - White,	American Indian, Black,
136 thin 72 hours in the "naturs edical Exami	Completed b	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+		during mo	's Usual Occupation of working life. On Worke	DO NOT us			16b. Kind of Busin	ness/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical	Be Con	17. Father's Name (First, Middle, Last) Warren Percy Brown				8.Mother's N		rst, Middle, M e Brow	aiden Surname)	On
MD 21; nd 2 should be alth and Men no 27 is mar	To E	19a Informant's Name/Relationship (Type, Print) Sandra K. Sedwick/Step-Daug	 hter			and Numbe	r or Rura	Route Numb	per, City or Town, ryland,	
ore, Nest and of Health If item		20a Method of Disposition 1 Burial 2 X Cremation 3 Removal from State	20b. P		tion (Name of cem	etery,			20c. Location - C	
Baltimore, permit. Pages I at Department of Hee Important: If ite		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee M00053	Hur	ntt Crer	natory ame and Address	Ma of Facility		, 2006 3035 (rf, Maryland
m ឱ្ង≝្ឋា Physician	11 1	Mand Denhaw 23a Part I. Enter the disease, or complications that caused the		Hur Do not enter th	ntt Fune	al Ho	me	POB 15	6. Waldo	rf, MD 20604
/Medical examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a Hypertensive Ath Due to (or as a conseq	eroscle	erotic Cardio			lac of Tes	spiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
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ted 1 insit	Examiner	(Disease or injury that initiated events resulting in death) Last	uence of):						
60, tte be execut nysician and e burial - tra	dical	UNPENDED AMENDED								
Records, P.O. Box 68760, The law requires that the death certificate be executed care has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome 1 Live birth 4 Pregnant at tire 9 Unknown		2 Feta	al death 3 er (Specify)	Ectopic pro	egnancy		23d. Date of de Month	livery Day Year
res that the signed by the be detache	by Ph	Part II. Other significant conditions contributing to death be Chronic Alcoholism; s/p throat Cancer; s/p			nderlying cause giv	ven in Part I.				te to the cause of death?
rds, requires		official According sty titleat cancer, sty	COIOIT	esection	<u></u>		- 1	24a Was ar	24b. Wer	Probably 4 Unknown re autopsy findings available
	Completed							autopsy perform 1 V Yes 2	ed? deal	r to completion of cause of th? Yes 2 No
of Vital ng Physician After this certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 🔲 I	ER/Outpatient		of Death (Ch	eck only ursing Ho		esidence 6 🗸	Other: Scene
on of ending Pl ath or: After he funera	tion:	27. Manner of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day, Year	ð	28b. Time of In		at Work?		Describe ho	w injury occurred	
Division of Vital Hospital or Attending Physician: 24 hours after death Funeral Director: After this certifiely filled in by the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injur (Specify)	y - At hor	me, farm, street			28f.	Location (Str or Town, Sta	eet and Number o	or Rural Route Number, City
hin the	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner.	nowledge nation an	e, death occurre d/or investigation	ed at the time, date on, in my opinion, o	e and place, death occurr	and due ed at the	to the cause(s) and manner as	started. to the cause(s)
To wit	Me	29b Signature and title of dentifier			29c. License			I		(Month, Day, Year)
		nme and address of person who completed cause of dea	th (Item 2	23a)	O.C.M	.c.			May 2, 2006	
DB1871		Laron Locke MD. Assistant Medical Exam	niner	111 Penn :	Street, Baltimo	ore, MD 2	21201			
St. Regist	ate	31. Date filed (Month, Day, Year) 32. Squistrar's	signatur	K doo	and the same					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 6:05 P M 2 2006 Irene O. Bree May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 13351 Triadelphia Mill Road Clarksville Howard If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Oct 20, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Months 043 07 9956 86 1919 Connecticut Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Columbia Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5057 Durham Road West 21044 United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: If Yes, Give Year or Dates: White 3€ Widowed 4 □ Divorced 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "ne sny injury or other traumatic avent, If a Madic once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18 Mother's Name (First Middle Maiden Surname) 17. Father's Name (First, Middle, Last) Frederick Blake Annie Blehl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles L. Morseburg/Friend 8416 Thames Street Springfield, VA 22151 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem. Gard: 5-9-2006 Marriottsville, MD * 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee AM01044 Lotte 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4 FARS DEMENTA resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐ Yes 2 XNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 🔀 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) group home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2X No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1725947 May 3, 2006 30. Name and address of son who completed cause of death (Item 23a) (Type, Print) Dr. Evelyn Jackson 5540 Ten Oaks Road Clarksville, MD 21029 32. gistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006 MAY 0 9

DHMH 17 Rev 1/2001

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death

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The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

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To the Hospital within 24 hours a To the Funeral I

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physician

Baltimore, Maryland 21215-0036

ed other than "natural", or Items 23a or 28a-1 show svent, the Madical Examiner must be nutibled at

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 8:45 AM 5 2006 5 JAMES VINCENT BRYANT 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) FREDERICK 10303 FOX CHASE CIRCLE **NEW MARKET** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 5. Social Security Number WASHINGTON D.C. 84 2-21-1922 578-12-7147 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County DELAWARE SUSSEX OCEAN VIEW 1x Yes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 19970 37654 PINE STREET UNITED STATES 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 RYes 2 No If Yes, Give Year or Dates: 43 45 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) TELEPHONE COMPANY **FOREMAN** 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) COLUMBUS VINCENT BRYANT PEARL COLLINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) P.O. BOX 305, OCEAN VIEW, DELAWARE 19970 JAMES VINCENT BRYANT II/ SON Date 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State CAPE HENLOPEN CREMATORY 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5-5-2006 FRANKFORD, DELAWARE 5 Other (Specify) 4 Donation 21. Signature of Puneral Service Licens 22. Name and Address of Facility MELSON FUNERAL SERVICE, LTD. WEST AVE., OCEAN VIEW, DE 19970 ose, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximate Interval Between Onset and Death Piter the 23a. Part1 shock, or heart fail Immediate Cause (Final disease or condition resulting in death) METASTATIC ADEMOCANGROMA mo Due to (or as a consequence of): TEANS BLADDEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 ☐Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 - No 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 wither (Specify) RESIDENCE 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

The law requires that the death certificate be executed burial-transit the attending physician and Division of Vital Records, P.O. Box 68760, the jo has pade 2 or Attanding Physician: this After i after death.

Physician

/Medical

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Funeral

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Physician/Medical

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Certification: To

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29b. Signature and title of certifier

Examiner

Funeral

Director

item 27 is marked other than "natural", or Items 23s or 28e-f show other traumatic event, it a Madical Examinar must be multical

Hygiene.

Pages 1 and 2 should be inent of Health and Mental Int: If item 27 is marked o

permit. Pages Department of Importent: If it any injury or o

Physician

/Medical

Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

tilled in by the funeral director, within 24 hours a To the Funeral I completely To the

D17/0+1

Registrar

31. Date filed (Month, Day, Year) State

MEMOCAL

mD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 156

MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

D-31912

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Y OPOSSUM TOWN PIUE

2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 4:54 A M Shirley Jeane Bright May 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Hospital Hagerstown Washington County If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Day, Year) 10 1943 1 ☐ M 2 💢 F 63 Feb Tennessee Director 217-40-4879 Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a. State 10b. County *ohe 27 is marked other than "natural", or teme 23a or 28a-f ebov traumatic event, if a Medical Examinar must be notified at 1 ☐ Yes 2 No Director ÞΔ Fulton Needmore 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 4235 Timber Ridge Road 17238 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Personal Residence Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Clara Gladys Hooten Rosenburg ပ Lynn Echert Rosenburg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 Benjamin Cleon Bright (husband) 4235 Timber Ridge Road Needmore Pennsylvania 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Smithsburg Crematory 5-9-06 Smithsburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 willow MMI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) I durito mor **Physician** /Medical Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 2 Fetal death 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2- No 3 Probably 4 Unknown 1 ☐ Yes been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has b lirector, page 2 sl has autopsy performed? 1 Tyes 2 No 2 100 or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Japiter A hours after dea.

-val Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral Completely filled i Hospitai 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) ş 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 101 cause or death (Itam 23a) (Type, Print) and address of person who completed (11) 11110 hod 3. Date filed (Month, Day, Year) 32. 1 gistrar's Signature State I tecars town MAY 2006 Registrar

		1 - For Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artment of H	lealth an D <i>eath</i>	d Mental	Hygien) 6	160	07
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Examir		4a. Facility Name (If not institution, g	ive street and numb	oer)		4b. City, Town, or	Location of D	Death	4	c. County of	Death		
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Funeral		,	Sex 7. 1 ☐ M 2 🖾 F	Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hours		, Day, Yea	7)	9. Birthpla Counti	ace (State o	r Foreign
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and w		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10	d. Inside Ci	ty Limits
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death ms 2	Funeral	11. Marital Status	12. Was Decede	ent Ever in U		Was Decedent of Hi	spanic Origin	? (Specify Yes o	r No-	14. Race			
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be fi	Be	17. Father's Name (First, Middle, Las Paul H. Kephart	51)					Name (First, Mid		n Sumame))		
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2 8 5 E 5 D		1 Burial 2 ☐ Cremation 3			ametery, crer	natory or other place	9)						
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Hygiene. Department of Hygiene.		21. Signature of Funeral Service Lice	ensee			MONEY Addres							
		23a. Part1. Enter the disease, or cor	mplications that cau	sod the deat	b Do not ont	71 W. Mar	ole Ave	., Vien	na, V	a. 22		A na vavimata	
		snock, or heart failure. List only	y one cause on eac	h line.	II. DO NOT ent	ar the mode of dying	g, such as can	diac or respirato	ry arrest,			Approximate nterval Betv Onset and D	veen
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Atte	ific	3 ☐ Suicide 6 ☐ Could not determined	a 286. Place of	Injury - At ho	ome, farm, stre	et, factory, office			n (Street a. Town, Stat	nd Number	or Rural F	Route Numb	er,
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To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	1	29a. Certifier 1 ☐ Certifying P	hysician: To the be	est of my kno	wiedge, death	occurred at the time	e, date and pl	ace, and due to	the cause(s	and mann	er as stat	ed.	
the H in 24 the F plete	Medical	one)	nminer: On the basi and manner	stated.	uon and/or inv	өэнданол, ні ту ор	mion, death o	ccurred at the tir	ne, date an	u piace, and	aue to ti	ie cause(s)	
To I To t	Σ	29b. Signature and title of certifier	//	7		29c. License	number		29d. Da	ate signed (I	Month, Da	y, Year)	
10		Junda /	n/ken	UP)		D3599	6			5/3/	06		
10		30. Name and address of person who	completed cause of	of death (Item	n 23a) (Type, I								
		Linda M. Burrel	1, M.D.				iversi	ty Blvd	W. 7	400.W	Theat	on, M	d.
Sta		31. Date filed (Month, Day, Year)	32. Peg	istrar's Signa	iture	auth							
Registr	ar	MAY 08	2006	EURI I	J. 19								

VOID

CERTIFICATE

06-16008

SEE

CERTIFICATE #

06-22973

deceased: Mila Jean Belle 500: 579-06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 11 11

			For State Registrar		State of Ma	ryland /			Health and f Death	мептат ну	gienę Reg. No.	2006	1600	7
	Physici	an	Decedent's Name (First)			Dales			Cr.	2. Date of De	ath Day	Year	3. Time of Deat	
	/Medic	al	James 4a. Facility Name (If not in	H.	reet and number)	Bake		b. City, Town	Sr. , or Location of De	ath	40.	County of Dea	10:261	141
	ZXdiiiii		Memoria	1 Hos	pital	(In yrs. last I	histodays	If Under 1 Year	Voerlan	rs 9 Date of Bir	1	o Die	jany	nica
	Funeral Director		 Social Security Number 234-64-3776 	6. Sex	M 2□F 6			Months Day			, 194	41	toplace (State or Ford	
	land ow		Usual Residence of Deced	lent County		10c. City, To							10d. Inside City Lin	nits
	e Mary	ctor	MD A	Allegany		V	Veste	nport					1 □ Yes 🔏 □	No
	be filed within 72 hours after death with the Maryland tal Hyglene. Id other than "natural", or iteme 23a or 28e-f ehow event, the Medical Exacili wir meal to inclified at	Funeral Director	10e. Street and Number 412 Spruce	Street				10f. Zip Code	21562		10g. Citi	zen of What C	ountry?	
	teme 2	unera	11. Marital Status	12	2. Was Decedent 8 Armed Forces?		13. Wa	s Decedent of	of Hispanic Origin? uban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	-	14. Race - Am Black, Whi		
920	urs afte al', or l	by Fi	1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ D		1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:	0	1 🗆	Yes 2 N	lo Specify:			Specify: wh	ite	
21215-0036	"natur	Completed by	15. D (Specify only	ecedent's Educa highest grade	ation completed)	16	(Give kil	nt's Usual Occ nd of work don NOT use ret	ne during most of v	vorking	16b. Ki	nd of Business	/Industry	
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and	should be fited and Mental Hygin marked other imatic event, II	Be	17. Father's Name (First, I							lame (First, Middle Rounds				
Maryland	iit. Pages 1 and 2 should artment of Health and Men ortant: If tem 27 is marke Injury or other treumatic.	7	19a. Informant's Name/Re	elationship (Typ		1:	9b. Mailing	Address (Stre	et and Number or	Rural Route Numb	er, City o	r Town, State,	Zip Code)	
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Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 eny Injury or other ti 2002.		1 Burial 2 Crer 4 Donation 5 C		moval from State	Scarpe	elli Fun	eral Hon	ne, P.A	4/27/2006	Cre	esaptow	n MD	
Balt	permit. P Departm importar eny Injur		21. Signature of Funeral S	Service License	IM	111	/ 22.1	Scarpe 108 Vi	elli Funeral Irginia Aven	Home, PA ue: Cumbei	for :	Fred1oo MD 2150	k Funeral H 02	lome
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Division	or Atter efter dea Director Director	Certification:		Could not be determined	28e. Place of Inju- building, etc	iry - At home, . (Specify)	, farm, stree	t, factory, office	сө	28f. Location (City or To			tural Route Number,	
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	To th within To th compl	Me	29b. Signature 10 110 o	certified	A			29c. Lice	ense number		29d. Dat	e signed (Mon	th, Day, Year)	
)			30. Name and address of	A S	moleted cause of d	eath (Item 22	a) (Type Pi	int)	18316		4	126/0	56	
			Steven R.	Smith	m.D. 9	00 S	etan	Drive	Combo	cland	MD.	21205	À	
	Sta		31. Date filed (Month, Da	y. Year) 5 20	06 32. Régistra	ır's Signature	e A	and B						

		1 - For Amend Item	State of Marylar 29d per Dr.,				Mental Hyg	giene Reg. No. 2006	16010
Physic /Medi		1. Decedent's Name (First, Middle, Las Geraldine M. Cas					2. Date of Dea	Day Year 5 2006	3. Time of Death 736 P M
Exami		4a. Facility Name (If not institution, give Washington Count				or Location of Dea Restow:		4c. County of Death Washi	4
Funeral Director		5. Social Security Number 6. S 552-36-6998 1				If Under 24 Hrs	8. Date of Birth	9. Birth Cot 5,1923 Penn	nplace (State or Foreign unity) Sylvania
paritified by Mary Viality A. I.Z. 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23s or 28a-1 show any injury or other traumatic event, the Madical Evantical must be notified at any piges.	ral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Frederi 10e. Street and Number 1210 Arnoldst	own Road		erson 10f. Zip Code	21755		10g. Citizen of What Cou United S	tates
tours after de urai', or items	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:	1	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🔀 N	f Hispanic Origin? (: uban, Mexican, Puel o <i>Specify:</i>	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White Specify: Whi	e, etc.
within 72 h ane. than "natu	Completed	15. Decedent's Ed (Specify only highest gra Etementary/Secondary (0-12) 1.2	de completed) Cotlege (1-4or 5+)	16a. Dece (Give life.		le during most of wo red) -	orking	16b. Kind of Business/I	
Mar y Idii w x 1 x 13-0030 d 2 should be filed within 72 hours at th and Mental Hyglene. ? Ie marked other than "naturel", or traumatic event, the Mexical Exem	To Be Co	17. Father's Name (First, Middle, Last) William Loga			Homema	18. Mother's Na	me (First, Middle, na Silkwo		me
and 2 shot alth and N 127 ie ma		19a. Informant's Name/Relationship (Judy Cochran /	,, ,					r, City or Town, State, Z. MD 21793	ip Code)
permit. Pages 1 ar Department of Hea Important: If tem any injury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification of Funeral Service Licer	Removal from State	ederic	2. Name and Add	ory 5/10 tress of Facility S	tauffer	20c. Location - City or 1 Frederick, Funeral Hom ederick, MD	Maryland e
Physician /Medical Examiner hysicien and the burial-transit	cai Examiner	23 Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.) Lace of the deadler of t	quence of):		He u a	1	rest,	Approximate Interval Between Onset and Death
The law requires that the death certificat as been signed by the ettending phy age 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	□Ectopic pregnar □ Other (specify)	ncy		23d. Date of dein Month	very Day Year
for attending Physician: The law requires that ited each. Director: After this certificete has been signed by in by the funeral director, page 2 should be deta		Part II. Other significant conditions of	- 1	sulting in the u	inderlying cause (given in Part I.	1 🗆 Y		the cause of death?
To the Hospitel or Attending Physician: The law within 24 hours effer death. To the Funeral Director: After this certificate has t completely filled in by the funeral director, page 2	Completed	,					24a. Was a autop perfor 1 \(\text{Yes}	sy prior to o death?	opsy findings available ompletion of cause of
sicia	Be	25. Was case referred to medical examiner?	Hospital:	2500) th ==	eath Check only or	-	
Phy rathis	7.	1 No 27. Manner of Death	1 Sinpatient 2L	_ ER/Outpatie	III JUDON	4 🗆 Nuising		ence 6 Other (Spec	ify)
Attending Physician: r death. ector: After this certifice by the funeral director, p	Certification:	1 □Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not b	1000	est.2i	W I	☐ Yes 2 🔼 No	Felldo	SWK Ataki	
To the Hospitel or Att within 24 hours etter of To the Funeral Direct completely filled in by		4 Homicide determined 29a. Certifier 1 Certifying Ph	Home	eify)			12 City or Ton	n, State oldstan	2175)
• Hos 24 h • Fun letely	edicai	(Check only 2 Medical Exar	ysician: To the best of my kn niner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my	y opinion, death occ	urred at the time, o	tate and place, and due	stated. to the cause(s)
To th withir To th	Me	29b. Signature and title of certifier	D. 40	-15		_ 1062		May 8, 20	006 / 6
3		30. Name and address of person who Eduare W. Diffo				Lenoce	Ad t	+65ers6000	40
St Regis	tate trar	31. Date filed (Month, Day, Year) MAY 1 0	2000 32. Registrar's Sign	nature	Smalle				

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Fred. Co. #29 D

		1	For State Registrar	State of Maryland		artment of H			ene g. No.2 0 0 6	16011
**	Physicia		Decedent's Name (First, Middle, Last) Sidney Colle	ageman				2. Date of Death Month April	Day 2006	3. Time of Death 9:07P. M
	/Medic Examin	al	4a. Facility Name (If not institution, give st	reet and number)	51/4		Location of Death		4c. County of Deat	h
	Funeral		3310 N. Leisure Wo 5. Social Security Number 6. Sex	7. Age (In yrs. I			If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug • 24,	9. Birt	hplace (State or Foreign puntry) Lorado
100	Director		215-10-7027 X Usual Residence of Decedent 10a. State 10b. County		/, Town or Lo	cation		U		10d. Inside City Limits
	the Maryli 28a-f eho	rector	Maryland Montgomer	·y S:	ilver	10f. Zip Code		10	g. Citizen of What Co	X□Yes 2□No puntry?
36	be filed within 72 hours after death with the Maryland and Hygiene. A let Hygiene and then "naturel", or items 23a or 28a-f ehow ed other than "naturel", or items 23a or 28a-f ehow event, the Medical Exaction must be nutilied.	by Funeral Directo	3310 N. Leisure Wor 11. Marital Status 1 Never Married 2 Amarried 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	S. 13.	2090 Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	U. S. A. 14. Race - Ame Black, Whit Specify: W	e, etc.
Baltimore, Maryland 21215-0036	ithin 72 hour ne. hen "nature!'	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	dent's Usual Occup kind of work done DO NOT use retired hemical I	during most of wor d)		16b. Kind of Business	,
and 21	d be filed w ental Hygier ked other ti c event, ID	To Be Col	17. Father's Name (First, Middle, Last) Louis Collegeman	4 16415		Trompour 1	18. Mother's Nar	ne (First, Middle, M Murray	faiden Sumame)	
Mary	ind 2 shoul alth and Me 27 is marl ar traumati	-	19a. Informant's Name/Relationship (Type Esther B. Collegema	рө, Print) an — Wife	19b. Mailii 3310	ng Address (Street N. Leist	and Number or Ru ure World	BIAG.	# 514, Md	ær°∞5pring, . 20906
imore,	permit. Pages 1 and 2 should be fit Department of Health and Mental Hi important: if Item 27 is marked oth ery injury or other traumatic even once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Ki	ng Dav	osition (Name of matory or other pla	Gdns 4-30	2006		ch, Virginia
Balt	Departi Departi import eny inj		21. Signature of Funeral Service License	tatte me	1	001 Pools	7111 Dil	Rocky	tion, Inc. ille, Mary	1and 20852
80	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Parot	id Car	cinoma	ng, such as carola	c or respiratory arre		Interval Between Onset and Death
	/Medical Examiner	-	Sequentially list conditions	Due to (or as a consec Rena1	Failu	ıre				
8760,	cate be executed physicien and tha burial-transit	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CHF	quence of):					
.O. Box 687	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	al death 3	□Ectopic pregnand □ Other (specify) _	·y		23d. Date of de Month	alivery Day Year
Δ.	uires that the signed by Id be detacted	by	Part II. Other significant conditions con	ntributing to death but not re	sulting in the I	underlying cause g	ven in Part I.			to the cause of death? Probably 4 □Unknown
Records,	The law requir ate has been si page 2 should	Completed						24a. Was a autops perform	v prior to	
Vital	Phyaician: Trust certificated real director, principles	o Be	25. Was case referred to medical examiner? 11√∑ Yes 2 ☐ No	lospital: 1 ☐ Inpatient 2 ☐] ER/Outpatie	ent 3□ DOA O	hon	ath <i>(Check only on</i> Home 5 X Reside	re) ence 6 ⊡Other (Sp	ecify)
Division of	ef ef	Certification: T	27. Manner of Death 1 Natural 2 Accident 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	M 10	ork?]Yes 2 □ No		ow injury occurred	Rural Route Number
Divi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined	28e. Place of Injury - At he building, etc. (Special sician: To the best of my kn	iry)			City or Town	n, State)	
	the Hosp in 24 ho the Fune tpletely f	ledical	(Check only 2 Medical Exami	ner: On the basis of examin and manner stated.	ation and/or i	nvestigation, in my	opinion, death occ	curred at the time, d	ate and place, and du	ue to the cause(s)
)	70	Σ	29b. Signature and title of certifier	5, 1	10	D61	.696		April 28	
	0 -		30. Name and address of person who can Dr. Sharon Yang.	M. D. 3305	North	Leisure W	World Blv	d., Silve	er Spring,	Md. 20906
7. 安	Si Regis	ate trar	31. Date filed (Month, Day, Year) MAY 0 9 2	32. Fegistrar's Sign	de la	backer				_

		1	For State Registrar	State of Maryland		artment of H tificate of L			jiene _{eg. No.} 200	0	16012
	AC.		Decedent's Name (First, Middle, Last)					2. Date of Dea Month		ear 3	3. Time of Death
П	Physicia		Barbara	Stephenson	Coc	hran		May	2, 200	06 2	2:27 P. M
	/Medio Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	1	4c. County of	Death	
			Shady Grove Advent	ist Hospital		Rockvi			Montg		<u> </u>
	Funeral Director		5. Social Security Number 6. Se:		est birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb. 24	, Year)	Kentu	4
	و <u>م</u>	-	Usual Residence of Decedent 10a, State 10b, County	10c. City	Town or Lo	cation				10d.	Inside City Limits
	show	2					~~				1 ☐ Yes 2 🛣 No
	28a-f	Directo	Maryland Montgom 10e. Street and Number	ery Mo	ntgom	ery Villa	.ge		10g. Citizen of Wha	at Country	?
	with	ā	9449 Chatteroy Pla	200		20886			United	State	eg
	ns 23	era	11. Marital Status	12. Was Decedent Ever in U.S	5. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No-	14. Race -	American	Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23a or 28a-f show important: If item 27 is marked other than "natural, or items 23a or 28a-f show any injury of other traumatic event, the Modical Examinat must be notified at once.	by Funeral	1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ⊠ No	Specify:	o Hican, etc.)	Specify:	White, etc.	
21215-0036	2 hou		15. Decedent's Edu	ication	16a. Dece	dent's Usual Occup	ation	ting	16b. Kind of Busin	ness/Indus	try
215	hin 7.	pie	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT use retired	1)	A.H.G			
21	giene giene	Completed		4	Но	omemaker			Home		
nd	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar		Maiden Sumame)		
Maryland	Men Men Marke Marke	ို	William	Stephenson	105 14-10		and Number on Dr	Floren			
Лaг	2 sh and and is m	H	19a. Informant's Name/Relationship (T)			ng Address (Street					
6	and tealth		Gavin H. Cochran/I		-	Chatteroy	Place,	Date	20c. Location - Ci		
Baltimore,	S E E		1 ☐ Burial 2 ☑ Cremation 3 反	Removal from State	metery, cre	matory or other plac		10006		•	
ţ	t. Pa rtmen rtant:		4 ☐ Donation 5 ☐ Other (Specify,	4 7 7		tan Crema 2. Name and Addre			Alexandr		Irginia
Bal	Depa mpo mny ir		In use of Fulleral Stylica Licens	/ lulder		East Dee					20877
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death						A	pproximate iterval Between
8760,	death certificate be executed a attending physician and of or use as the buriat-transit graph	edicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence. Due to (or as a consequence. Due to (or as a consequence.	uence of): /	yo cardia	I Ing	Farc tro	1		nset and Death 30 Minutes
9	tificat ng phy as th	ledi									
O. Box	he death certifica the attending ph ched for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	□Ectopic pregnanc □ Other (specify) _	ý		23d. Date Month	-	ay Year
Vital Records, P.O.	law requires that the de as been signed by the i 2 should be detached	þ	Part II. Other significant conditions co	ontributing to death but not resu	ulting in the u	underlying cause giv	ven in Part I.		obacco use contrib res 2 □ No ~	Probab	
CO	w require been sign	Completed						24a. Was			y findings available
Re	o - g	Ę.							rmed? de	or to comp ath? ☐Yes ~ 2[iletion of cause of
ā	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only o	7) 103	Zino
5	Physician: rthis certific ral director.	To B	examiner? 1 Yes 2 No	Hospital: ↑ ☐ Inpatient 2 🖾	ER/Outpatie	int 3 DOA Ott			dence 6 □Other	(Specify)	
on of	ing After une		27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju Wo	ry at		how injury occurred		
Division	P # # □	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, s	treet, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	or Rural R	łoute Number.
	To the Hospital or At within 24 hours after or To the Funers! Direct completely filled in by	edical C	29a. Certifier (Check only one)	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, dea tion and/or i	th occurred at the ti nvestigation, in my	me, date and place	e, and due to the urred at the time,	cause(s) and man date and place, an	ner as state nd due to th	ed. ne cause(s)
	To th within To th compl	₩ W	29b. Signature and title of certifier	,		29c. Licens	se number		29d. Date signed	(Month, Da	ly, Year)
	М		1 B. H 2-	an		05	1980		Man &	2,2	006
	. (30. Name and address of person who	completed cause of death (Iten	n 23a) (Type	, Print)			1	1	- September 1
			Brett Gamma, M.D.	, 9901 Medical	Cent	er Drive,	Rockvil:	le, MD.	20850		
**	St Regis	ate trar	31. Date filed (Month, Day, Year) MAY 0 9	32. Abgistrar's Signa	ature	parti					

Registrar DHMH 17 Rev 1/2001

State

William's port, Maryland 21795

31. Date filed (Month, Day, Year)

MAY 1

2006

32 Segistrar's Signature

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Reyli Benitez Carvajal 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month May 7, 2006 1607 hrs Reyli Benitez Carvajal Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Route 40 near Crystal Falls Drive Hagerstown 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 6. Sex **Funeral** Foreian Months Days Hours Min. Director 1963 Country) Mexico June 6, $_{1}X_{M}$ 149-84-2963 2 F Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location any 10a. State 1 X Yes 2 No 28a-f show Hagerstown Washington Maryland hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe or items 23a or 28a-must be notified at U.S.A. 21740 232 Willard Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 2 X No Yes Mexican Mexican f Yes, Give Year 1 X Yes 2 No specify: Specify Divorced 3 Widowed <u>چ</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hou
Department of Health and Mental Hygene.
Important: If item 27 is marked other than "nat
injury or other traumatic event, the Medical Exa College (1-4 or 5+) Elementary/Secondary (0-12) Finisher Dry Wall 9 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elena Benitez Popoca Be Pedro Carvajal Vences 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2012 Rigley Point Court Odenton, Maryland 21113 (Brother-In-Law) David Joya 20b. Place of Disposition (Name of cemetery Date 111 20c. Location - City or Town, State Tejupilco Estavo Ve crematory or other place)
Cando Santo
Cemetery 1 X Burial 2 Cremation 3 Removal from State Mexico 51400 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 MO1414 e Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Mudical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and cian/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Physi icate has been signed by the att page 2 should be detached for Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? certificate has ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) director, 25. Was case referred to medical To the Hospital or Attending Physician: Division of Vital Be examiner? Hospital: 1 Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes No After the 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) May 7, 2006 27. Manner of Death 28b. Time of Injury Deceased driver of vehicle in collision with Certification: 1526 hrs within 24 hours after death.

To the Funeral Director: A completely filled in by the fun Natural 1 Yes 2 ✔ No 5 Pending another vehicle 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) Rt. 40@ Crystal Fall Drive, Hagerstown, MD determined (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 29a. Certifier 1 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. May 8, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year)

State

Registrar

2006

Director 226-50-7382 1	
Funeral Director Memorial Hospital at Easton Easton Easton Talb	eath.
Usual Residence of Decedent	
10a. State 10b. County 10c. City, Town or Location Condova 10e. Street and Number 10f. Zip Code 10g. Citizen of What 10g. Citizen of Wh	Birthplace (State or Foreign Country) LNGLNLC
106. Street and Number 107. Zip Code 108. Street and Number 109. Citizen of What 110. Was Decedent of Hispanic Origin? (Specify Yes of No. All Parks) 110. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
To be the second of the second	tes of America mencan Indian, hite, etc. aucasian
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 17c. Father's Name (First, Middle, Last) 18d. Mother's Name (First, Middle, Maiden Surmame)	truction
The state of the s	e, Zip Çode)
Russell Taylor Brother-in-law 6383 Carolina Avenue, Glen Burnie, Mar 200. Date 200. Location - City cemetery, crematory or other place) Russell Taylor Brother-in-law 6383 Carolina Avenue, Glen Burnie, Mar 200. Date 200. Location - City cemetery, crematory or other place) Taylor Brother-in-law 6383 Carolina Avenue, Glen Burnie, Mar 200. Date 200. Location - City cemetery, crematory or other place) Taylor Brother-in-law 6383 Carolina Avenue, Glen Burnie, Mar 200. Location - City cemetery, crematory or other place) Taylor Brother-in-law 6383 Carolina Avenue, Glen Burnie, Mar 200. Location - City cemetery, crematory or other place) Taylor Brother-in-law 6383 Carolina Avenue, Glen Burnie, Mar 200. Location - City cemetery, crematory or other place) Taylor Brother-in-law 6383 Carolina Avenue, Glen Burnie, Mar 200. Location - City cemetery, crematory or other place) Taylor Brother-in-law 6383 Carolina Avenue, Glen Burnie, Mar 200. Location - City cemetery, crematory or other place) Taylor Brother-in-law 6383 Carolina Avenue, Glen Burnie, Mar 200. Location - City cemetery, crematory or other place) Taylor Brother-in-law 6383 Carolina Avenue, Glen Burnie, Mar 200. Location - City cemetery, crematory or other place) Taylor Brother-in-law 6383 Carolina Avenue, Glen Burnie, Mar 200. Location - City cemetery, crematory or other place) Taylor Brother-in-law 6383 Carolina Avenue, Glen Burnie, Mar 200. Location - City cemetery, crematory or other place) Taylor Brother-in-law 6383 Carolina Avenue, Glen Burnie, Mar 200. Location - City cemetery, crematory or other place) Taylor Brother-in-law 6383 Carolina Avenue, Glen Burnie, Mar 200. Location - City cemetery, crematory or other place) Taylor Brother-in-law 6383 Carolina Avenue, Glen Burnie, Mar 200. Location - City cemetery, crematory or other place) Taylor Brother 6383 Carolina Avenue, Glen Burnie, Mar 200. Location - City cemetery, crematory or other place) Taylor Brother 6383 Carolina Avenue, Glen Burnie, Mar 200. Location - City cemetery, cr	or Town, State
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	yland 21629 Approximate Interval Between Onset and Death
Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
So and the past 12 months? 1 Yes 2 No 9 Unknown Yes 2 No 3 Unknown Yes 2 Yes 2 No 3 Unknown Yes 2 Yes 2 No 3 Unknown Yes 2 Yes	delivery Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3	e to the cause of death? Probably 4 □Unknown
The state of the s	autopsy findings available to completion of cause of 1? /es 2 No
1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (S	
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Modern one)	due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Compared to the compared	

			•	For State Registrar	State	of M	aryland		rtmen <i>tificat</i>				lental Hy	giene Reg. Noc	2006	5 16	5016
	ž.	1 1	A.	Decedent's Name (First, Middle	e, Last)				.,				2. Date of De Month 5	Day	Yea		e of Death
_		Physicia /Medic	al	CARLOS		CRU							5			56 20:	59 p ^y
		Examin		4a. Facility Name (If not institution union Hos		number))		_ ,,	kto		of Death		4C. (Ceci.		
		<u> </u>		5. Social Security Number	6. Sex	7. Ag	ge (In yrs. Ia	st birthday)	If Under	1 Year	If Unde	r 24 Hrs.	8. Date of Bi	rth	9. 8	lirthplace (Sta	ate or Foreign
	· ·	Funeral Director		205-44-3630	1 ☐ M 2 ☐	F	53	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Di 2/4/	1953	PI	JERTO	RICO
		D >		Usual Residence of Decedent 10a. State 10b. County			10c. City.	Town or Lo	cation							10d. Insid	le City Limits
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		ith the Marylar or 28a-f show	Director	md Cec	<u> </u>		Cire	sape	10f. Zip	Code				•	zen of What	Country?	
		death with the Maryland ms 23a or 28a-f show	ai D	179 Basil Av	enue					191					JSA ————	_	
		r dea	Funerai	11. Marital Status	Armed	d Forces		S. 13. 1	Was Dece f Yes, spe	dent of H cify Cuba	lispanic C an, Mexic	rigin? (Sp an, Puerto	ecify Yes or N Rican, etc.)	0-	Black, W		
1	36	rs afte	by Fi	1 ☐ Never Married 2 ☒ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes	es 2 🔀 , Give or Dates:			1 🛚 Yes	2□ No	Specif	y: Pue	rto R	ican	Specify:	HISPA	NIC
. 1	5-0036	72 hours after death with the Maryla rnatural', or items 23e or 28e-f shov cical Examiner rust be notified at	ted	15. Deceder	nt's Education	tod)		16a. Dece	dent's Usu	al Occup	ation	ast of work	ına	16b. Kir	nd of Busine	ss/Industry	
N	21215		Completed	Elementary/Secondary (0-12)	_ -	ge (1-4or	5+)					ost of work					
5	121	iled w tygier ther th		17. Father's Name (First, Middle,	Last)			Far	mino	As		tant hers Name	e (First, Middle		Farmi Sumame)	ng	
4	anc	d be f ental h	To Be	Andre							C	arme	n Cruz	2			
4	Maryland	shoul ind Mari i mari	-	19a. Informant's Name/Relation				19b. Maili	ng Addres	s (Street	and Num	ber or Rur	al Route Numi	ber, City or	Town, Stat	e, Zip Code)	015
N	Σ	is 1 and 2 should be filed within 72 hours after death wi of Health and Mental Hygiens in a fural; or items 23a item 27 is marked other than "natural; or items 23a other traumatic event, the Madical Examinational to the traumatic event.	1 9	MARY B. CRU	Z		201 20				ve,		sapeak			or Town, Star	
-91	altimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. mportant: If Item 27 is marked other than may injury or other traumatic event. The Manay injury or other traumatic event. The Manay injury or other traumatic event.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ∑ Removal f	rom State	20b. Pl	ace of Dispo metery, crei	natory or a tri	me or other plac CK	ce)		0/06	Ken	nett	Squar	re,
F	E E	permit. Pages Department of Important: If I any injury or one		4 Dona kg 5 Other (Ceme	Mama	nd Addro	ss of Fac	ality				lvani	
U	Ba	permit. Departi		23a. Part1. Enter the disease, of	Mu	5		K	UZO	& 9	rie	co F	H, ker		t Squ	are,	
of	A. B.	Physician /Medical Examiner and physician and physician and the privile remail than the privile remail than the privile remail that the privile remail that the privile remail that the remainer and the remainer	icai Examiner	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Acq Du b. Le. Du	e to (or a	is a consequence	ience of):	sal ere	/sul	bare (a	ver	oid 1	bilee ury:	E sin	Onset	years
	P.O. Box 68	ath certific ittending p or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 🗀 L 4 🗆 F	ive birth	ne of pregna 2 Fetal at time of de	death 3	⊒Ectopic ; ⊒ Other (s		У				23d. Date of Month	delivery Day	Year
	σ.	res that the de signed by the a be detached f	by Ph	Part II. Other significant condi	ions contributing	to death	but not resu	alting in the u	inderlying	cause gr	ven in Pa	rt I,				e to the cause	
	ords	w require been sig should b	ted t	Houte n	140car	dia	l i	ntain	10	Λ			1	Yes 2	□ No 3□	Probably	4 Unknown
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	Z.	sicier s certif lirecto	To Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:	1 □ Inpa	tient 2 1	ER/Outpatie	nt 3 🗆 🗅	Ot Ot	her		th <i>(Check only</i> ome 5□Re		6 □Other (5	Specify)	
	1 of	ding Phy h. After this funeral c		27. Manner of Death	28a. I	Date of Ir	njury Day Year)	28b. Time o		28c. Inju	iry at		28d. Describe	e how inju	y occurred		
	sior	death. ctor: Af	catio	1 Natural 5 Pend 2 Accident inves 3 Suicide 6 Coul	tigation				М		Yes 2	□No	28f. Location	(Ctract or	od Alverbas a	- Dural Doute	Alimbor
) V	or Attence after death Director: in by the	ertification:	4 Homicide deter	inad 206.	Place of I building,	etc. (Specify	ome, farm, s y)	reet, facto	ігу, опісе			City or T	own, State)	nuiai noute	TVUITIDEI,
	1	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical Co	29a. Cartifor 1 S Certify (Check only 2 Medical	ing Physician: I al Examiner: On	the basis	of examina	Wladge, dea	th secure	det the t	inte date opinion, o	and place death occur	and dile to the	e, date and	and manne d place, and	r as statad due to the ca	use(s)
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		7 × 5 0		Loo. digitalis dire the discontinue	whi	n	7/			T	WIN	066	,	M	24 6	3.2	200(_
•				30. Name and address of person	n who completed	cause o	of death (Item	n 23a) (Type	, Print)	4	7 0	- PR			11		- 40
	_	2		Savar &	- Su	th	ork	nd	MI)							
		St Regist	ate	31. Date filed (Month, Day, Yea	8 2008		strar's Signa	ture	Con	2							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month MAGI 08/3 2000 Ruth Α. Calhoun 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince onest ville 6 con 1638 Tulip Ave me If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Days 1 ☐ M 2 🖾 F Yrs 482-48-5740 Dec. 14, 1938 Kansas City, Mo. 67 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State XXYes 2 □ No Maryland Prince Georges Forestville 10g. Citizen of What Country? 10f. Zîp Code 10e. Street and Number United States 20747 1638 Tulip Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Government College (1-4or 5+) Elementary/Secondary (0-12) Budget Analyst 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Percy C. Wilburn Sallie Clayton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1925 Dale Rd. Cincinnati, Oh. 45237 Mary C. Titus / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 12, 2006 Cincinnati, Oh. Vine St. Hill 22. Name and Address of Facility
Alexander S. P
5538 Marlboro 21. Signature of Funeral Service Licensee Pope Funeral Homes, P.A. Pike/Forestville, Md. 20747 MOIUSS 23a. Palt1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheros devotic Cardioviscular Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

/Medical **Examiner** Examiner or Attending Physician: The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical this certificate has been signed by all director, page 2 should be detact Be Completed by : After this certifical funeral director, Medical Certification: To death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A the filled in by

Physician

Physician

/Medical

Examiner

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Haalth and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evantment to notified at ones.

Baltimore, Maryland 21215-0036

23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions o	ontributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Honknown
			24a. Was an autopsy performed? 1 Yes 2 700 10 Yes 2 700 Yes
25. Was case referred to medical		26. Place of De	eath Check only one
examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	t 3 DOA Other: 4 Nursing	Home 5. Residence 6 □Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Tyes 2 No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Cartifying Ph (Check only one)	nysicien: To the best of my knowledge, death niner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occ	ce, and due to the cause(s) and manner as stated curred at the time, date and place, and due to the cause(s)
30h Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

State Registrar

completely

29b. Signature and title of certifier

SATVAdor

2. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 0 8 2006

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30. Name and address of person who commeted cause of death (Item 23a) (Type, Print)

3001

Sequentially list conditions: Sequentially list conditions: Sequentially list conditions: Due to (or as a consequence of): Due to (or as a				1 - For State Registrar	State of	Marylan		artmer <i>rtificat</i>			nd M	ental H	lygiene Reg. No	< 111	16	16018
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Physician Medical Examinor To make the cause (Final Talkins, List only one acuse on an each line. The condition resulting in death) The condition resulting in death but not resulting in the underlying cause given in Part I. The condition resulting in death but not resulting in the underlying cause given in Part I. The condition resulting in death but not resulting in the underlying cause given in Part I. The condition resulting in death but not resulting in the underlying cause given in Part I. The condition resulting in death but not resulting in the underlying cause given in Part I. The condition resulting in the underlying cause given in Part I. The condition resulting in the underlying cause given in Part I. The condition resulting in the underlying cause given in Part I. The condition resulting in the underlying cause given in Part I. The condition resulting in the underlying cause given in Part I. The condition resulting in the underlying cause given in Part I. The condition resulting in the underlying cause given in Part I. The condition resulting in the underlying cause given in Part I. The condition resulting in the underlying cause given in Part I. The condition resulting in the underlying cause given in Part I. The condition resulting in the underlying cause given in Part I. The condition resulting in the underlying cause given in Part I. The condition resulting in the underlying cause given in P	Ba	Perm Depa Impo eny i		2 Xanaldla	Pell	les		R. N.	Hor	ton C	ompa	ny Mo	rtici •Wash	ans, inote	Inc	р. с. 20011
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature at title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Dey, Year) 29d. Date signed (Month, Dey, Year) 20d. Name and at tress of person who completed cause of death (Item 3a) (Type, Print) 20d. State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	a	n: Th ficate or, pag		25. Was note referred to madical						26 Place	of Doat			0 1	∐ Yes	2 No
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Leslie W. Kingslow, M.D.; 1160 Varnum Street, N.E.; Suite 214; Washington, D. C. State 31. Date filed (Month, Day, Year) 32. Registrar's Signature.		⊬ ≱ ⊢ ŏ		X/slui 1	11.16				DC2	0132			Ma	y 4	, 2	006
Leslie W. Kingslow, M.D.; 1160 Varnum Street, N.E.; Suite 214; Washington, D. C. State 31. Date filed (Month, Day, Year) 32. Registrar's Signature.	2	7		30. Name and a liress of person who	completed caus	e of death (Ite	an 23a) (Type	e, Print)								20017
	_	6		Leslie W. Kings				um S	treet	, N.E	.; 5	Suite	214;	Washi	ingt	
	3			31. Date filed (Month, Day, Year) MAY 0 5 2006	32. R	egistrar's Sign	nature	Vi .								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#26,perYerbal (857,7/24/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 13:28 PM HURCH 06 IRGINIA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1 CDMICO 35172 VAUGHNS ANE If Under 1 Year | If Under 24 Hrs. Birthpface (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 1 F Yrs. 220-18-1502 Director -18 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director JANTICO CDMIC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 21856 SA 238 Completed by Funeral 5656 THO Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Brack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. 11. Marital Status Yes 22No 1 Never Married 2 Married Maryland 21215-0036 ō 1 Yes 2 No Specify Specify AC 3 Widowed 4 Divorced Year or Dates "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TITCHEN UMSERS LANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be if Health and Mental EBECT ٩ RVIN KISHOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21804 DMITH PAUCHTER

20b. Place of Disposition (Name of cemetery, crematory or other place) LISBURY 20a. Method of Disposition 20 2/1 altimore. Date 20c. Location - City or Town, State ō = 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 0 permit. Page Department of Important: If eny injury or once. HEBREN, SPRINGHILL C 5/11/06 EM 21. Signature if Funeral Service Licenses 22. Name and Address of Facility BENNIE MITH ST. SALISBURY MD 2180 00 SABEIL A Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. fmmediate Cause (Final disease or condition **Physician** ardiopulmene resulting in death) /Medical Due to (or as a consequence of): **Examiner** Endomethial S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed End Stage
Due to (or as a consequence of): resulting in death) Last Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the inector, page 2 s autopsy performed 2 🗌 No 212 No 1 Yes 1 🗌 Yes Hospital or Attending Physician: Be (director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence examiner Hospital: 1 ☐ Yes 2 ☐ NO 1 fnpatient Certification: To 2 ER/Outpatient 3 DOA his 27. Manner of Death 1 Natural funeral 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by 4 - Homicide 29a. Certifier 🖼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Fo the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 00057333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shore derive, 813-B Eastern Mehta, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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			For State Aggistrar	State of Maryland		artment of H		and Me		ene	16020
*	di di Sac	, -	Decedent's Name (First, Middle, Last)					2	Date of Death	n Day Year	3. Time of Death
2.	Physicia /Medic		Eleanora	Deter						2006	7:30a ^M
	Examin	. A	4a. Facility Name (If not institution, give s			4b. City, Town, or	Location o	of Death		4c. County of Dea	th
			Genesis Sever			Severn				Anne Ar	undel
·g^	Funeral		5. Social Security Number 6. Sex	114 0575		If Under 1 Year Months Days	If Under 2 Hours	Min.	. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
16.2	Director		214-14-5275 Usual Residence of Decedent	99	113.				09-28-	-1906	MD
	and and		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mary f sh	ğ	DE Susse	x I	ewes						1 ☐ Yes 3 ☐ No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10	0g. Citizen of What Co	ountry?
	3a o		48 Kings Cross	ing		29	958			USA	
	death	Funeral		12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Orig	gin? (Speci	fy Yes or No-	14. Race - Ame Black, Whit	
9	or ite	E.	1 Never Married 2 Married	1 ☐ Yes 2 ☐No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:	,	, , , , ,		hite
93	thin 72 hours after death with the Maryland e. en "natural", or tteme 23a or 28a-f show Medical Examinatinat be notified at	d by	3 Widowed 4 Divorced	Year or Dates:							
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d 2	be filed withir ital Hygiene. Ital ether then event, tre m	O O	17. Father's Name (First, Middle, Last)					or's Name (First, Middle, N	Maiden Surname)	, iii C
an	T to D	To B	John J. F	lynn			L	ena	Piepe	er	
Maryland 21215-0036	d 2 should th and Men 7 is marke treumatic	-	19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street a	and Numbe	er or Rural F	Rou <i>te Number</i> ,	City or Town, State,	Zip Code)
	tre tre		Donna Wade - Gr	andaughter	48 F	Kings Cr	ossi	ng, I	Lewes,	DE 2995	8
Baltimore,	_ = = =		20a. Method of Disposition	0.	lace of Dispo	osition (Name of matory or other plac	e)	Dat	e :	20c. Location - City or	Town, State
Ë	Page nent c int: If		1 ☐ Burial 2 【XCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Ca	rroll	Cremat	ion	05-08	8-06	Hampstea	d. MD
alti	permit. Pages 1 Department of H Important: If Ite any Injury or ot		21. Signature of Funeral Service Licens	96	2:	2. Name and Address	ss of Facilit	ty		MILLIACON SERVICES AND	577707.58.842.1
Ω	88 5 6		John X960	MOO5						tead, MD	21074
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death ne cause on each line.	n. Do not en	ter the mode of dyin	g, such as	cardiac or i	respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Preum	none	$\dot{\alpha}$					days
	/Medical Examiner		resulting in death)	Due to (or as a consequence	uence of):						0
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	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Lue to (or as a conseq	uor co ory						
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,092	be executed sician and burial-transit	calE	•								
687	5 × 6			1.							
Box	eath certific attending pl	N	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna		7e				23d. Date of de	livery
Ď.	death certifica e attending ph id for use as th	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta		Ectopic pregnancy Other (specify)				Month	Day Year
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ord	w require been sig		advanced	aeriuri	1101				1 L Ye	es 2 □No 3 □ P	robably 4 Unknown
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		lo lo	27. Manner of Beath 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Wor	k? K? Yes 2 ☐		d. Describe no	ow injury occurred	
isi	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Pface of Injury - At he	ome farm st				f. Location (St	reet and Number or F	Rural Route Number,
Division	after Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specif	y)	, , , , , , , , , , , , , , , , , , , ,			City or Town	n, State)	
_	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 1 Tertifying Phy	sician: To the best of my kno	wledge, dea	th occurred at the tir	ne, date an	nd place, ar	d due to the ca	ause(s) and manner a	is stated.
	ne Ho	Medical	(Check only 2 Medical Exemi	iner: On the basis of examina and manner stated.	ition and/or in	ivestigation, in my o	pinion, dea	ath occurred	at the time, d	ate and place, and du	e to the cause(s)
8 1	within To the	×	29b. Signature and title of certifier		11	29c. Licens	number	_		9d. Date signed (Mon	oth, Day, Year)
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	7		Jennita	dinger	Seul	Veter	015	1141	7/11/	WOVSVIL	0 1011
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 2006 9:42A MAY 3, ALLAN LEE DANOFF /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner OLNEY MONTGOMERY MONTGOMERY GENERAL HOSPITAL 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign If Under 1 Year Months Days If Under 24 Hrs. 5 Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Hours 1⊠M 2□F 70 AUG. 1, MARYLAND Director 219-32-4722 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylam Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f ehow enjoinent: If item 27 is marked other than "natural", or items 23a or 28a-f ehow enjoinent or other traumatic event, the Modeal Examination or other traumatic event, the Modeal Examination of other traumatic event, the Modeal Examination of the profiled at once. 10a State 10b. County 1X Yes 2 No MONTGOMERY ROCKVILLE MARYLAND Director 10g. Citizen of What Country? 10e, Sireet and Number 10f. Zip Code 20853 U.S.A. 5405 NORBECK ROAD Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1959-61 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DENTISTRY 5+ DDS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ESTHER RABOVSKY PHILIP DANOFF ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5405 NORBECK ROAD, ROCKVILLE, MARYLAND SONDRA M. DANOFF/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State JUDEAN MEMORIAL GDNS 05/07/2006 OLNEY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signature of Funeral Service onald. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the plath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiovascula-Physician /Medical Examiner and opplmona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 donknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Ab 24a. Was an this certificate has al director, page 2 autopsy performed 1 Yes 20 Hospital or Attending Physician: : After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 No declared Hospital: Other: 1 Inpatient 2 ☐ ER/OutpatienI 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending 1 Tyes 2 ∏No death. investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funaral Direct 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Med Der MGH 05/03/2006 1)050410 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18161 Prince Phil 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 9 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month /) 5 **Physician** 1545 06 IANE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Snow Hill HARRISON Senior WORCESTER JUING If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) EIKTON, M() 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Hours Min 1 ☐ M 2 😿 F Yrs. 216-76-4843 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 Ia marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Evamins must be notified at 1 Yes 2 □ No CECIL Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 201 BANKS 2191 Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be APER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ChesapEAKe City 201 BANKS St. DEARL GUZMAN MOTHER 20b. Place of Disposition (Name of competery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Department of H Important: If ite any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 05/10/06 CheSADEAKE Cit hemia MANir (en. 22. Name and Address of Facility
Bennie Smith Fungral 1/2
417 W ISA BELLA ST. Solls 21. Signatus of Funeral Service Licensee 30/13 bury, MO 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) button neumona Physician /Medical or as a consequence of): Examiner we Sequentially list conditions, I say leading I immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a for sequence of): Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica within 24 hours a

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

BA 2

State Registrar

29b. Signature and title of certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1604 - Market St., Po Comoke 1604 - Market MAY 0 8 2006

R. BARAL,

and manner stated

SARAD

MI)

29c. License number

D54422

21851

29d. Date signed (Month, Day, Year)

(410-957-9488)

		4	For State Registrar	State of Ma	ryland			e of L		una ivi		Reg. No.	2001)	1004.0
			1. Decedent's Name (First, Middle, Last)							2. Date of De. Month	ath Day	Year		3. Time of Death
	Physicia /Medic		Ja	mes A. Dic	kens,	Jr.					May	5	2006		10:01P
*	Examin		4a. Facility Name (If not institution, give	street and number)			- '		Location of	of Death			County of De		
			1214 Alexander Av	enue				onsv:					Baltin		
	Funeral		5. Social Security Number 6. Se		(In yrs. las	st birthday)	If Unde Months	r 1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)	9. B	irthplace Country	e (State or Foreign
10	Director		226 46 7111	XM 2□F 70		Yrs.					March	31,1	936 V	'irg	inia
	უ .		Usual Residence of Decedent		10 - Cit.	Town or Loc	ation							10d	. Inside City Limits
	how	_	10a. State 10b. County		ioc. City,	TOWN OF LOCA	ation							100	1 ☐ Yes 2 ☑No
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	72 hours after death with the Maryland natural; or Itema 23a or 28a-f ahow Jical Examination to notified at	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		. 13. W	as Dece Yes, spe	dent of Hi orly Cuba	spanic Ori n, Mexican	gin? (Spe 1, Puerto l	cify Yes or No Rican, etc.)	- 1	14. Race - An Black, Wh		
9	or h	F	1 Never Married 2 Married	1 ☐ Yes 2 🔀 N If Yes, Give	0	1	☐ Yes	2 № No	Specify:				Specify:		
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	lygie her t		17. Father's Name (First, Middle, Last)			Mal	nten	ance	18. Mothe	ar's Name	(First, Middle				
DU.	be fi	Be	James A. Dickens,	Sr.					Luel						
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if the firm 27 is marked other than "natural", or Hema 23a or 28a-f ahow then traumatic avant, the Medical Enactine must be notified at	2				10b Mailine	- Addros	c /Ctroot :			l Route Numb	er City or	Town State	Zin C	ode)
Jai	2 st and is n		19a. Informant's Name/Relationship (7												
	1 and 2 Health tem 27 i		Shane Dickens/Son 20a. Method of Disposition		20b. Pla	1214 A			c Ave		tonsvil		cation - City of		n, State
o o	Pages 1 nent of P int; If ite iry or ot		1X Burial 2 ☐ Cremation 3 ☐	Removal from State	Cel	metery, crem	atory or	other plac							
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Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signature of Funeral Service Licen	, who	M0104										y FH Inc. D 21043
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水	Physician /Medical Examiner	ner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a				yeu c	ry C					5 /4	~ N H'
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	o the	Me	29b. Signature and title of certifier		2		2	9c. Licens	e number			29d. Dat	e signed (Mo	onth, Da	ay, Year)
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(3)	n_		30. Name and address of person who	complete	eath (Item	23a) (Tune	Print)	/	, , ,					00	
حى	UM		MICHAILL PUNT	e11, J48	VMC	494	10 1	EDMA	A VA	ve !	PAUT IM	re 1	WZ	122	4)
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			1 - For State Registrar	State of Marylan	•		t of Heale of Deale		•	giene Reg. No.	ZUIII	160	24
	6,2		1. Decedent's Name (First, Middle, Last,				~ `		2. Date of Dea	ath Day	y Year	3. Time of De	
	Physici /Medio		Richard	H.			Dai	S	May	5	2006	1:08	РМ
ř	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or Loca	ation of Death	0 1 (4c.	County of Death		
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ı	Funeral Director		5. Social Security Number 520-60-3170 6. Set	7. Age (In yfs.	last birthday) Yrs.	If Under Months		Jnder 24 Hrs. ours Min.	8. Date of Birt	1'9'4'	Coul	place (State or F ntry) ansas	oreign
	pu k		Usual Residence of Decedent 10a, State 10b, County	10c. Cit	y, Town or Loca	ation						Od. Inside City I	Limits
	sho	ö	Md. Howard		Ellicot		-vz					1 ☐ Yes 2	
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	ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13. W	as Deced	lent of Hispan	nic Origin? (S	pecify Yes or No-	.	14. Race - Ameri		
^	riter	臣	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	lf '	Yes, spec	offy Cuban, M	exican, Puert	o Rican, etc.)		Black, White,		
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	ysici is cer direc	ToB	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 ☑ Inpatient 2 □	ER/Outpatient	3□ DC	Other: 4	I ☐ Nursing H	lome 5 Resid	dence	6 □Other (Specia	(v)	
ō	g Ph ter th teral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	2	8c. injury at Work?		28d. Describe	now injui	ry occurred		
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	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C		rsician: To the best of my kno iner: On the basis of examina and manner stated.									
	orthin orthin ompl	Me	29b. Signature and title of certifier			290	. License nu	mber		29d. Da	te signed (Month.	Day, Year)	
	6 .		D M	VI MA		4	PFS.	000		M	2. 5	LV.	
	1		30. Name and arress of person who co	ompleted cause o death (Iter	n 23a) (Tvne. P	Print)				1.10	4 , 6	106	
	7			etzer, MD	600 N	, Wh	Ifo Si	t. R. 1	Almore A	AD	ay 5, 2 21287		
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature					- -			
	Regist	rar	May no 2	BBB Aller	M - A								

ORIGINAL

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Anais Meram Flore Douga 2006 16025 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 1855 hrs Medical Examiner May 9, 2006 Anais Meram Flore Douga 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7 Age (In vrs. last birthday) **Funeral** Months Days Hours Min Director Country) Maryland M 2 X F 220-73-6209 2005 DEC 14. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 X No Maryland Montgomery Silver Spring hours after death with the Maryland Director s 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11407 July Drive #301 20904 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian Black Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes 1 Yes 2 X No specify. Widowed Divorced If Yes. Give Year Specify: Black ≥ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. MD 21215-0036 Infant Infant 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Babikir Lydie Koumbairia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is r traumatic 11200 Lockwood Drive #1201 Edith Koumbairia/Aunt Silver Spring, MI
20b. Place of Disposition (Name of Cemetery, 20a. Method of Disposition 20c. Location - City or Town, State 3altimore, crematory or other place) 1 👿 Burial 2 Cremation 3 Removal from State mportant: of Heaven 5/16/06 4 Donation 5 Other Specify: Silver Spring, MD . Name and Address of Facility 21 Signature of Funeral & vice License Thibadeau Mortuary Service, P.A. 933 Gist Ave., LL., Silver Spring, M00956 Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a Psuedoephedrine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate couse E ter Underfuing Couse (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical x AMENDED item#23a,27,28a-f,perME,G857,//24/06 TI item#28f,perME,g857,7/28/06 TT UNPENDED attending physician or use as the burial Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death Division of Vital Records, P.O. Box 68760, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 ✔ No 9 Unknown Unknown signed by the contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? this certificate ✓ Yes 2 No ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other 1 🗸 Yes No 28a Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 1 Yes 2 No 5 Pending Fnd 5/9/2006 Fnd 6:10 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1509 December Driver pt 101, Baltimore, MD Silver Spring, 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be 3 Suicide determined Other-Scene Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

a 24 hours after www....ae Funeral Director: A

State Registrar

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d Date signed (Month, Day, Year)

May 10, 2006

and manner stated

Assistant Medical Examiner

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Zabiullah Ali, M.D.

		1	State of Maryland / Department of Health are State Amend Item 24a per verb. 6856 06/27/06dab registra Amend Item #5 Per FH G856 6/29/106atg 01/106atg 01/106atg	ind Me	Date of De	eath		3. Time of Death
/IV	/siciai ledica amine	1	Carl Jefferson Delp, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	f Death	Month May	10	Day Year 2006 4c. County of Dea	5:00A M
Fund Direct	eral	ı	Spa Creek Center 5. Social Security 1704 190-12-1704 110 M 2 F 82 Annapolis If Under 1 Year If Under 24 Months Days Hours	Min.	8. Date of Bi (Month, D Jan 25	rth ay, Yea		indel hplace (State or Foreign ountry) ginia
Baltimore, Maryland Z1Z15-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 271s marked other then "neturel", or Items 23e or 28e-1 show	The Medical Examiner must be putities at	rai Director	Usual Residence of Decedent 10b. County 10c. City, Town or Location	of working	g	USA o-	14. Race - Am Black, Whi	erican Indian, te, etc. hite Vindustry
Baltimore, Maryland bermit. Pages 1 and 2 should be file Department of Health and Mental Hy mportent: If item 27 is marked othe	any injury or other treumatic event once.	10 00	Carl J. Delp, Sr. 19a. Informant's Name/Relationship (Type, Print) Carl J. Delp, III/ son 20a. Method of Disposition 1	Mae : rorRural Steve	Pugh D Route Numb ensvil ate	elp per, City le, 20c. Gr	y or Town, State, Marylar Location - City of	ad 21666 Town, State
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al Records, 1: The law requires t icate has been signe	2 should	Completed by	Chimic abstration primary desert		24a. Was auto perf 1 \(\text{Yes}	s an opsy ormed?	24b. Were a prior to death?	robably 4 Unknown utopsy findings available completion of cause of s 2 No
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To the Hospitel within 24 hours a To the Funerel	completely	Medical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death and manner stated. 29b. Signature and title of certifier 29c. License number	h occurred	d at the time	29d. [and place, and du Date signed (Mon	e to the cause(s)
Po	Stat		30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	riv	e 4	est.	er, Mis	2/6/9

		•	1- For State of Maryland / De	partment of F ertificate of			giene) (16	161	027
	Physici		Decedent's Name (First, Middle, Last) WARREN RHYS EVAN	S		2. Date of Dea Month May		Year 06	3. Time o	of Death P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Homewood at Crumland Farms	4b. City, Town, o			4c. County o	of Death	k	
i	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 2 1 1 1 1 2 1 1 1 1 2 1 1 1 1 2 1 1 1 1 2 1 1 1 1 2 1 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 1 2 1 1 1 1 2 1 1 1 1 2 1 1 1 1 2 1 1 1 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(ay) If Under 1 Year Months Days	If Under 24			9. Birtho	olace /State	or Foreign
poetra	2		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of			-			10d. Inside (City Limits
h the Ma	r 28a-f s	Director	Maryland Frederick Freder 10e. Street and Number	ick 10f. Zip Code		1	0g. Citizen of W	hat Cou	Λ	s 2 □ No
4	23a c	ralD	7401 Willow Road Apt. #422	21702			U.S.			
ind Z 1 Z 1 C 0000	hal Hygiene. Ital Hygiene. Ita	by Funeral	11. Marital Status 1 □ Never Married 2 Married 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Argued Forces? 1 ② Yes 2 □ No If Yes, Give Year or Dates: WWII	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	dispanic Origin an, Mexican, F Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race Black Specify:	k, White,	can Indian, etc. ite	
20 C 1	n "natural	Completed t	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	ecedent's Usual Occup ive kind of work done fe. DO NOT use retired	during most of	f working	16b. Kind of Bus			
7 7	giene.	Com	Elementary/Secondary (0-12) College (1-4or 5+) 6+	Teacher			Educ		on	
	and Mental Hygiene. Is marked other than aumatic svant, ITEM	To Be	17. Father's Name (First, Middle, Last) Raymond NMI Evans			s Name (<i>First, Middl</i> e, . e Knapp	Maiden Sumame	a)		
IVICAL Y IC		9	19a. Informant's Name/Relationship (Type, Print) Penelope, Flowers / Daughter-in-law			or Rural Route Number				
,	rages I and nent of Health int: If itam 27 iry or othar tr		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State	sposition (Name of crematory or other plan	·	Date	20c. Location - 0			
	Department Important: any injury			urg Cremat		/10/06 & SON FUN	Smithsbu			.and
ă	Depar Impo		Sakers	1201 MORTH	MARKE	T ST FRE	DERICK		21701	
	Francisco .		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final	enter the mode of dyir	ng, such as ca	rdiac or respiratory arr	est,		Approxima Interval Be Onset and	stween
	nysician /Medical xaminer		disease or condition resulting in death) a Due to call a consequence of:	4-					Yes	15
	M NA	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying					_	1	
6	physician and stransit	Examiner	frany, leading to immediate cause. Enter Underlying Cause (Lie 24s or i Jun) that initiated events resulting in death) Last Due to (or as a consequence of):					-		
	physiciar the buri	dlcai E	d							
O. DOY O	attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknow	3 □Ectopic pregnancy 5 □ Other (specify) _	у		23d. Date Mon		-	Year
. L (2)	ules that the de signed by the a d be detached to	þ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause giv	ren in Part I.		bacco use contri	bute to t		death?]Unknown
	he law req e has beer ige 2 shou	Completed	Balder Cancel, Valvalor	hante	liseas	24a. Was a autops perform	med? pr	rior to co eath?	opsy findings ompletion of	available cause of
ומו	rtificate ctor. pa	Be Co	25. Was case referred to medical examiner?		26. Place of	1 Yes 1 Death (Check only of		Yes	2 No	
> 10 10 10 10 10 10 10 10 10 10 10 10 10	Austraing Frysician: The law requires us er deator: After this certificate has been signed by the funeral director, page 2 should be de	은	1 Yes 2 Hospital: 1 Inpatient 2 FR/Outpa 27. Manner of Death 1 Natural 5 Pending 1 Natural 5 Pending 1 Natural 5 Pending	e of 28c. Injur	ry at		ence 6 Other		fy)	
	no the nospital of Attanta within 24 hours after death. To the Funeral Diractor: A completely filled in by the fa	ertification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)]Yes 2⊡No		treet and Numbe n, State)	r or Rura	al Route Nur	nber,
	no the nospital or Attain within 24 hours after deat To the Funeral Diractor: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o and manner, stated.							(s)
1	To th comp	Me	29b. Signature and little of certifier	29c. Licens		2	9d. Date signed	(Month,	Day, Year)	
IN	X		30. Name and address of person who completed cause of death (Item 23a) (Ty	D164	28		3/1	16	10	
(,			Casper E. Cline, III, MD 300 West	9th Street	, Fred	erick, MD 2	21701			
	Sta Registi		31. Date filed (Month, Day, Year) 0 2006 32. Resistrar's Signature	forthe						

DHMH 17 Rev 1/2001

warren Evans

sician 1.	State Registrar	Otate of t	•	partment of Health and e <i>rtificate of Death</i>	Reg.	2006	16028
sician	. Decedent's Name (First, Middle,	Last)			2. Date of Death Month	Day Year	3. Time of Death
edical	Doris Lu	cille Eise	-n		May	5 2006	4:10 A. M
	a. Facility Name (If not institution,	give street and number	er)	4b. City, Town, or Location of De	ath	4c. County of Death	
	Westminster Nu			Westminster		Carroll	
Idi	Social Security Number 223–22–7087A	1. Sex 7 1 ☐ M 2 💢 F	Age (In yrs. last birthda 81	y) If Under 1 Year If Under 24 H Months Days Hours Mi	in. (Month, Day, Ye		ece (State or Foreig ry)
	Isual Residence of Decedent		01		Jul 20,	1924 Virg	IIIIa
	0a. State 10b. County	-	10c. City, Town or	Location		10	d. Inside City Limits
Director	MD Carrol	1	Westmins	ter			1 ☐ Yes 2 🙀 No
le 10	0e. Street and Number			10f. Zip Code	10g.	Citizen of What Count	try?
la [311 Shagbark Rd.			21157		ited States	
Funeral	1. Marital Status	12. Was Decede Armed Force	s?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - America Black, White, e	
by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	d 1 □ Yes 2 { If Yes, Give Year or Date:	€XN°	1 ☐ Yes 2√XNo Specify:		Specify: Whit	te
ed	15. Decedent's		16a. De	cedent's Usual Occupation	168	b. Kind of Business/Ind	ustrv
Completed	(Specify only highest	grade completed)	(Gi	ve kind of work done during most of w . DO NOT use retired)	vorking		,
E	Elementary/Secondary (0-12) 4th	College (1-4d	Cater	ing	F	ood Service	2
Φ 1	7. Father's Name (First, Middle, La	ist)		9	lame (First, Middle, Mai		
P F	Howard Thomas			Irene Co	orbin		
	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	illing Address (Street and Number or	Rural Route Number, C	ity or Town, State, Zip	Code)
	Connie Alsruhe (daughter)	5177	Perry Rd. Mt. Ai	ry, MD2177	1	
20	0a. Method of Disposition 1 Burial 2 □ Cremation 3	Bemoval from Sta	20b. Place of Dis	position (Name of rematory or other place)		c. Location - City or Tov	vn, State
	4 □Donation 5 □ Other (Spe			alley Mem. 5/9/2 22. Name and Address of Facility	2006 Tim	onium, MD	
2	21. Signature of Funeral Service Li	censee		22. Name and Address of Facility			50/81
	mel A.	heller	~ F	urrier-Queen Fune	ral Home a	nd Cremator	y, P.A.
2	23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caus	sed the death. Do not	find the Mide of Shirt, shich scan	o Ro trat William	No.	Interval Between
	mmediate Cause (Final disease or condition	. chro	·	etrophino Pu	Monis	elisense	Onset and Death
	resulting in death)	_ d	as a consequence of):		2 11 2	W. 6	
c	Sequentially list conditions	b. Cor	gestin	e herst f	enme	alex-	
Examiner	Sequentially list conditions, f any, leading to immediate ause. Enter Underlying Cause (Disease or injury	Due to (or	as consequence of):				
cam	hat initiated events	c	as a consequence of):			1.0	
<u> </u>		Due to (or a					
1 and	esulting in death) Last		as a consequence or).				
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ㅁ	F FEMALE:	d					
ㅁ			ne of pregnancy	B⊟Ectopic pregnancy		23d. Date of deliver	y Day Year
ᇴ	F FEMALE: 23b. Was decedent pregnant	1 ☐ Live birth	ne of pregnancy 2	B⊟Ectopic pregnancy			,
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician a M Agnes Nolan Engels 5, 2006 3:06 May /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Spring
T Munder 24 Hrs. 8. Date of Birth (Month, Day, Year)
March 23, 1946 Montgomery Holy Cross Hospital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Year **Funeral** Days 1 ☐ M 2 ☐ F 60 Yrs. 213-46-8275 Washington, Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show the Medical Examiner roust be notified at 1 ☐ Yes 2 ☐XNo Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 12508 Greenhill Drive USA items 23a Funeral iit. Pages 1 and 2 should be filed within 72 hours after death riment of Health and Mental Hygiene. Arriant: if item 27 ie marked other then "netural; or items 23 milury or other traumatic event, the Medical Examinar must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifWhite Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Para-Educator Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be John A. Nolan Loretto R. Gowen 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Matt A. Engels/ Husband 12508 Greenhill Drive, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) May Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 2006 St. John's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland Deporting Importation 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. Will Eller 500 University Blvd, W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 3 Days a Sepsis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Liver Dysfunction from Breast Cancer 12 Months Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physicien and the buriel-transit Metastatic Breast Cancer 4½ Years Due to (or as a consequence of) Box 68760. Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year jo in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes Ž No 3 Probably 4 Unknown hes been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 Yes 2 No this certificate 1 ☐ Yes 28 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 12 Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 28 No 3 DOA Alter th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier D35996 May 5, 2006 mal. 10 30. name and address of person who complete cause of death (Item 23a) (Type, Print) 2730 University Blvd, West, Wheaton, Maryland 20902 Linda M. Burrell, M.D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAY 09 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day Year Month **Physician** 4:00P 2006 May Nancy Louise ESHLEMAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Mt. Airy
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Frederick Kline Hospice House 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🗰 F 218-38-1111 Dec. 21 1941 Director 64 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ehow. r than "natural, or items 23a or 28e-1 ehov the Medical Examiner stust be notified at 1 Yes 2 □ No Hagerstown Direct Maryland Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21742 IISA Funeral 1625 Woodlands Run 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No tf Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White 2 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Coltege (1-4or 5+) Flementary/Secondary (0-12) 0 Homemaker Her own home other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental Field marked of 99 Pages 1 and 2 should 2 Paul Lester Stoner Susan Gertrude Louise Forsythe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: if item 27 is eny injury or other tra once. 17706 Woodcrest Road, Hagerstown, Maryland 21740
ce of Disposition (Name of Date 20c. Location - City or Town, State <u> Carol Barger - Daughter</u> altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery | 5/13/06 Hagerstown, Md. 21740 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licenses Kolen 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Immediate Cause (Finat disease or condition resulting in death) **Physician** 80 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ut): Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 ☐ Other (specify) signed by the e P.O. 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 2 200 3 Probably 4 Unknown 1 Tyes should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has all director, page 2 s autopsy 2□ No 1 Yes 2[or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical KIME examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 N Certification: To perico After thi 27-Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time ot 28c. Injury at Work? 28d. Describe how injury occurred ù S 0 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. of Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funerei Dire To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

NX

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink

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			16800 Darnestown Road			E	City, Town, Boyds	OF LO	ation of L			Mo	ounty of D ontgome	ry		
	neral ector		5. Social Security Number 6. Sex 216-06-1745	7. Age (In yrs. 21	last birthday	· -	f Under 1 Y Months D	ear Days	If Under 2 Hours	24Hrs. Min.	8. Date of Birt June 1			oroian	lace (State o	or
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the Ho	To the Funeral Director: completely filled in by the	Medical	29a Certifier (Check only one) 2 Medical Examiner: On the	e basis of examination a	dge, death o	ccurred tigation,	at the time, in my opini	, date a ion, de	and place, ath occur	, and du red at th	e to the cause ne time, date a	e(s) and nand place,	nanner as s	started.	ause(s)	
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			For State Registrar	State of	Maryland		rtment o			nd Me		giene leg. No⊋ [106	16032
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	Physicia		1. Decedent's Name (First, Middle, Last)	M	ate of Death Month 1^{Day}	3. Time of Death 4:40 A M	
	/Medic	al	Helen Ivancoe Francis 4a. Facility Name (If not institution, give street and number)	May 4b. City, Town, or Location of Death		County of Death	
	Examin	er	Homewood Retirement Center	Williamsport	t t	ashington	
	Funeral	4, 0	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. D. Months Days Hours Min. (A	ate of Birth Month, Day, Year)	Birthplace (State or Foreign Country)	
	Director		075-14-2156 1□ M 2X F 95 Yrs.	07	Month, Day, Year) /21/1910	Czechoslovakia	<u></u>
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	3a or 28e	Funeral Director	10e. Street and Number 16816 Petmar Circle	101. Zip Code 21742	10g. Cit	tizen of What Country? US	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importent: If item 27 is marked other than "natural", or itams 23a or 28a-f show any highty or other traumatic event, I'm Medical Exert and must be inclifted a once.	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 □ NO	Was Decedent of Hispanic Origin? (Specify \\ If Yes, specify Cuban, Mexican, Puerto Ricar 1 ☐ Yes 2 X\(\text{No}\) Specify:	Yes or No- n, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
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Maryland	ild be file fental Hy rked oth	To Be (17. Father's Name (First, Middle, Last) Michael (unk) Ivancoe	18. Mother's Name (Firs Mary (unk)	st, Middle, Maiden Schneid	n Sumame) .er	
Mary	nd 2 shoulth and M		19a. Informant's Name/Relationship (Type, Print) Cheryl A. Light / POA 1331	ng Address <i>(Street and Number or Rural Ro</i> u 8 Maugansville Road,	Hagerst	or Town, State, Zip Code) .own, MD 21740	
Baltimore,	Pages 1 and neut of Head Int: If item Iry or othe		20a. Method of Disposition 1 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition of Dis	matory or other place)		ehold, NJ	
Balti	permit. Departm Importe any inju		21. Signature of Fungal Service Lice, see	2. Name and Address of Facility Geral 305 N. Potomac Stree			
<i>(4)</i>			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between Orsevand Death	
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):			Wilk	
967 40	Examiner	-L	Sequentially list conditions, b				
	scuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
760,	ate be executed hysicien and the burial-transit	ical Ex	resulting in death) Last Due to (or as a consequence of): d.				
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.O. Box	that the death certifica ed by the attending ph detached for use es th	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year	
<u>a</u>	se us	þ	Part II. Ottler/significant conditions contributing to death surnot resulting in the	underlying cause given in Part I.		use contribute to the cause of death?	n
Records,	The taw ete has b page 2 s	Completed			24a. Was an autopsy performed? 1 Yes 2 XX	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	0
Vital	ician: sertific ector,	Be	25. Was case referred to medical examiner? Hospital:	26. Pface of Death (Ch			
o	Phys this ral di	1: To	27. Magner of Teath 28a, Date of Injury 28b. Time	ent 3 DOA 4 Nursing Home	5 ☐ Residence Describe how inju	6 ☐Other (Specify) ury occurred	
lon	Attending r death. ector: After by the fune	ation	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division	of or Attendiated after death. Director: A din by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		Location (Street a City or Town, Stat	and Number or Rural Route Number, te)	
	To the Hospitel or Attent within 24 hours after death To the Euneral Director: completely filled in by the	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	th occurred at the time, date and place, and onvestigation, in my opinion, death occurred at	due to the cause(s t the time, date an	s) and manner as stated. nd place, and due to the cause(s)	
	within 2 To the	Me	29b. Signature modifie bicertifier	29c. License number	29d. Da	ate signed (Month, Day, Year)	
7	×10		30. Name and address of perkipn who completed cause of death (flem, 23a) (Type	TOW 1106)	16.	3/1/006	
			STEPHENE METERS IN 13424	12-AVE, STE-101 H	talden sta	ocu, MH 21742	
	St Regist	ate rar	31. Date filed (Month, Pay, Year) 2006 32. Segistrar's Signature	oude		•	

			For State Registrar	State of	Maryland		artment of F			Re	g. No.	006	16034
	Dhaminia		1. Decedent's Name (First, Middle,	Last)						2. Date of Deat Month	h Day	Year ,	3. Time of Death
	Physicia /Medic		John E. Fo						15 1	may	9,3	2006	11.24 M
	Examin	er	4a. Facility Name (If not institution, g				4b. City, Town, o					ty of Death ashing	rton
			Washington Count 5. Social Security Number 6		aı. 7. Age (İn yrs. İ	ast birthday)	If Under 1 Year	ersto		8. Date of Birth (Month, Day,			place (State or Foreign
	Funeral Director		175-40-9507	1 X M 2□F	89	Yrs.	Months Days	Hours	Min.	(Month, Day, Sept. 19	Year) 1916		sylvania
			Usual Residence of Decedent	•									
	nylan show		10a. State 10b. County		10c. City	, Town or Le							10d. Inside City Limits 1 ☐ Yes 2 XNo
	Ba-f s	cto	MC	nington			Boonsbo	ro			0g. Citizen o	4 MATERIA CONT	
	vith th	Funeral Director	10e. Street and Number				10f. Zip Code	21712	.	'	ug. Citizen d	U.S.	ŕ
	s 238	eral	212 Maple A		dent Ever in U.	S 13	1	21713		pecify Yes or No-	14. R	ace - Amen	
	ter de	Fun	XX Never Married 2 Marrie	Armed For	ces? 2 ⊡ No	1	Was Decedent of H If Yes, specify Cubi			Rican, etc.)		lack, White,	
036	hours after deeth with the Maryland tural; or Items 23a or 28a-f show at Examinar must be notified at	by	3 Widowed 4 Divorced	If Yes, Giv Year or Da	e 41	-46	1 ☐ Yes 2 🔯 No	Specify	' :		Spec	cify:	White
2-0	72 ho	Completed	15. Decedent's (Specify only highest			16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during mos	st of won	king	16b. Kind of	Business/Ir	dustry
21	within 72 ene. than "na	mple	Elementary/Secondary (0-12)	College (1	4or 5+)	life.	DO NOT use retired Prin				Prin	ting (Co.
12	filed w Hygier other ti		12 17. Father's Name (First, Middle, La	251)			PT TII		er's Nam	ne (First, Middle, I			
auc	d be fundal h	Be C	Frank Forne							nce Jumr			
Maryland 21215-0036	should nd Men marke umatic	To	19a. Informant's Name/Relationshi			19b. Maili	ing Address (Street					m, State, Zij	o Code)
	and 2 selth a n 27 is		Verona M. Crim	(Friend)	3593	Williams	port	Pike	Martins	burg,	WV. 2!	5401
ē,	of Her Item		20a. Method of Disposition 1 □ Burial 2 💆 Cremation 3	Demousl from		lace of Dispendence	osition (Name of matory or other pla	сө)	May	Date 11.	20c. Locatio	n - City or T	own, State
<u> </u>	Page nent ant: It		4 □Donation 5 □ Other (Spe		Sm i	thsbu:	rg Cremat	ory	200)6	Smith	sburg	,Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at 90cs.		21. Signature of Funeral Service Li	censee	's Mel		2. Name and Addre .L. Davis			Home 125	25 Br Lthsbu	adbur rg,Md	y Ave. . 21783
	×	_	23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that c	aused the deatl	n. Do not en	ter the mode of dyi	ng, such as	s cardiac	or respiratory arr	est,		Approximate Interval Between
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	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0	ROKE	,	MH P	7110	(1)	5 HE1	10001	LAGT	
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Box	eath certifice attending ph for use as tl	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live b	come of pregna irth 2 🗌 Feta	death 3	Ectopic pregnanc	у				Date of deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of the deliver of th	rery Day Year
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ita	ician: Th certificete rector, pag	Be (25. Was case referred to medical examiner?		/	ick .			ce of Dea	th Check only or	10)		
13 -	Physician: this certificantal director.	မှ	1 ☐ Yes 2 ☑ No			ER/Outpatie	SIL SU DOA		Nursing H	ome 5 Resid			ify)
, F C	fing After fune	io.	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investige		of Injury th, Day Year)	28b. Time Injury	Wo	rk?]Yes 2.[No	200. Describe II	ow injury occ	,01160	
Division	Attending r death.	ficat	3 Suicide 6 Could no	ot be 28e. Place	of Injury - At h	ome, farm, s	treet, factory, office					mber or Aui	ral Route Number,
Washing Division o	effer Dire	Certification:	4 Homicide	buildi	ng, etc. (Specil	(y)	•			City or Tow	n, State)		
2	To the Hospital or Attend within 24 hours effer death To the Funaral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the examiner: On the b and man	best of my kno asis of examina ner stated.	wiedge, dea ition and/or i	ath occurred at the transfer in my	me, date a opinion, de	and place ath occu	, and due to the d rred at the time, o	ause(s) and late and plac	manner as e, and due	stated. to the cause(s)
	within 2 To the complet	Me	29b. Signature and title of certifier	_	1,	0	29c. Licen				9d. Date sig	1 -	4
	_		Lun	Reno L	wolthos	PITAL	TRI DE	06	33	96	5/1	00	6
			30. Name and address of person of Purapaty	who completed caus	se of death (Iter	n 23a) (Type ntieto	an St	Hag	415	96 town 1	Mary	lano	/
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2006	legistrar's Signa		ente						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month 4:18 AM **Physician** anielle Nicole 3006 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN Washington
9. Birthplace (State or Foreign
WEST VIRGINIA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7/29/1985 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2 🂢 F 20 235-33-7669 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County other than "naturel", or Iteme 23a or 28a-f show vent, the Medical Examiner must be notified at 1 ☐ Yes 2 No HEDGESVILLE BERKELEY Director W۷ the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 25427 394 ALLENSVILLE ROAD death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. 1) Never Married 2 Married 1 ☐ Yes 2XXNo Specify: Baltimore, Maryland 21215-0036 Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) EDUCATION STUDENT 18. Mother's Name (First, Middle, Maiden Sumame) treumatic event, 17. Father's Name (First, Middle, Last) Be h and Mental I KIMBERLY FRENCH UNKNOWN ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 394 ALLENSVILLE ROAD, HEDGESVILLE, WV 25427 KIMBERLY FRENCH/MOTHER Heelth a Department of Heelth Important: if Item 27 eny Injury or other to once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ALCENSVI LLE" CEMETERY 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HEDGESVILLE, WV 4 ☐ Donation 5 ☐ Other (Specify) BROWN FUNERAL HOME, P.OMARTINESURG, 22WW 254519G ST., 21. Signature of Funeral Service Licensee Morgan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on part line. Approximate Interval B tween Onset and the Immediate Cause (Final menmoma Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury uance of): Due to (or as a cons-Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 🗆 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ 10 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and

State Registrar 31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

32. Registrar's Signature

		1	For State Registrar	State of Marylar		artment of Health a		l Hygien	71111	6	16036
	A. 90 V		Decedent's Name (First, Middle, Last,)			2. Date Mor	of Death	- V	'ear	3. Time of Death
F	Physicia		DENZ	IL HUGH	FERGU	SON	MA			06	6:45 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location of	of Death		c. County of		
26			SOUTHERN MARY			CLINTON	Od Hen la =		RINCE		
	Funeral		5. Social Security Number 6. Se	14 20E	last birthday) Yrs.	If Under 1 Year if Under Months Days Hours	Min. (Mo	e of Birth nth, Day, Year)	Counti	
	Director	-	NONE Usual Residence of Decedent	59	113.			. 8, 1	940	JAI	IAICA, W.I.
	land ow	- H	10a. State 10b. County	10c. Ci	ty, Town or Le	ocation				10	d. Inside City Limits
	Mary in sh	ţ	W.I. JAMAICA			KINGSTON,6					Y∏Yes 2 No
	72 hours after death with the Maryland natural; or Items 23a or 28a-f show dical Examinat Lanulliad al	Director	10e. Street and Number			10f. Zip Code		10g. C	itizen of Wh	at Count	ry?
	13 wit		13 GAINSBOROUG	H AVE.		NONE			JAMAI		
	ems frm	Funerai	11. Marital Status	12. Was Decedent Ever in L Amed Forces?	J.S. 13.	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican	igin? (Specify Ye n, Puerto Rican, (s or No- etc.)	14. Race - Black,	America White, e	
92	or it		1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes 2 No Specify:			Specify:	BLAC	עי
Ö	tural'	ed by	3 Widowed 4 Divorced	Year or Dates:	16a Dece	dent's Usual Occupation		16b.	Kind of Busi		
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Maryland	Aenta Aenta rked ric ev	ToB	LOUIS	FERGUSON			EULA	H (GRANT		
ary	and Nand Sand Nand		19a. Informant's Name/Relationship (T	ype, Print)	19b. Mail	ing Address (Street and Numb	er or Rural Route	Number, City	or Town, Si	ate, Zip	Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene it them 27 is marked other than "netural", or items 23a or 28a-1 show other traumatic event, its Modical Exercities must be notified at	1	CAROLYN FERGUSO			INSBOROUGH AV					
ore	of H		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 1	Removal from State	cemetery, cre	osition (Name of matory or other place)	Date		Location - C		
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Baltimore,	permit. Pages Department of Important: If It ony injury or once.		21. Signature of Funeral Service Lidens	1	00091	Z Name and Address of Each CHAMBERS FUNER 5801 CLEVELAND	ÄL HOME AVE., R	& CREM.	ATORIU LE, MI	лм,Р. Э. 20	A. 0737
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	Physician		Immediate Cause (Final disease or condition	011	10 Ca	Lanoma	Ĺ				Onset and Death
1	/Medical	3	resulting in death)	Due to (or as a conse							
F	Examiner		Esquentially list conditions.	, gancre		- 10					
	st sd	iner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a conse	quence of):	Ladure -					
	be executed sician and burial-transit	Exami	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):/	The contract					
8760,	be e) ician buria	calE		,		,					
687	physics the I	77		d	-	777					
×	death certificate be executed te attending physician and od for use as the burial-transit	lan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr					23d. Date	of delive	ry
Box	death a atter	Ciar	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		□Ectopic pregnancy □ Other (specify)			Mont	h	Day Year
o.	tt the de by the tached	Physici	9 Unknown	9□ Unknown							
٠, ص	de de	by P	Part II. Other significant conditions co	ontributing to death but not re	sulting in the	underlying cause given in Part	I. 23	e. Did tobacco	use contrib	ute to th	e cause of death?
ğ	w requires been sign should be							1 🗌 Yes	2 XNo 3	Prob	ably 4 □Unknown
Records,	law re as bee	Completed					24	a. Was an autopsy	24b. W	ere autop	osy findings available inpletion of cause of
Ä	The tage page	E					10	performed? Yes 2	de	ath? ☐ Yes	
Vital	ian: rtifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Plac	e of Death (Chec	k only one)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		
of V	Physician: this certific ral director,	10	1 Yes 2 No	Hospital: 1 Inpatient 2 [ursing Home 5				")
			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Work?		escribe how in	jury occurre	d	
sio		cati	Accident investigation 3 Suicide 6 Could not be		1	M 1 Yes 2		antina (Ctront			I Davida Alumbas
Division	i or Atten after deat Director:	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, tarm, s	treet, factory, office	Cil	y or Town, Sta	and ryumber ite)	Or Hura	l Route Number,
	spital hours meral (29a. Certifier 1 Certifying Ph	ysician: To the best of my kr	nowledge, dea	ith occurred at the time, date a	ind place, and du	e to the cause	(s) and man	ner as st	ated.
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check only one) Medical Examone) 29b. Signature and fitte of certifier	and manner stated.	nation and/or i	nvestigation, in my opinion, de			ate signed		
	3		Df fo	ulsin		140058	218			5/3	3/06
	7		30. Name and address of person who	D.O. MD	10st	Patrick Bour	e Sute	502	hald	of v	n020603
1	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 8	2006 Segistrar's Sign	A A	park					

			1- State of Maryland / Department of Health and Certificate of Death		ene2006	16037
1,5			Decedent's Name (First, Middle, Last)	2. Date of Death	1	3. Time of Death
	Physici /Medio		Robert Eugene Forree	Month	13 2000	0 5:30 PM
1	Examir		4a. Facility Name (If not institution, give Greet and number) 4b. City, Town, or Location of Deat	th	4c. County of Dea	th
\$17.		36	University of Many and Medical Center Bath more		NA	
	Funeral	4.	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1 Under 24 Hrs		Year) 9. Bir	thplace (State or Foreign ountry)
	Director		197-40-9047 XX 2DF 55 Yrs. Months Days Hours Min.	Sept.18	1950	PA
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d Incide City Limits
	anyla	2	Guartina 23	ield Twp.		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-f	Sct				1
	vith ti	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What C	ountry?
	a 234	ral	440 Lindy Road 17360	200-4-14-14-14	USA 14. Race - Am	-ine te di-
	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-1 ahow ita Medical Exama wr must be modified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (5	to Rican, etc.)	Black, Whi	
36	i', or	by	3 ☐ Widowed 4 ☐ Divorced Year of Dates:		Specify:	Thite
5-0036	tura en E	ed	15 Decedent's Education 16a Decedent's Usual Occupation	1	6b. Kind of Business	
215	Z uin 72	Completed	(Specify only highest grade completed) (Give kind of work done during most of wo life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	orking	~ .	
2121	d with	E O	4 Carpenter		Construc	tion
	oth vent,	Bec		me (First, Middle, M	laiden Sumame)	
<u>la</u>	uld b Ments rked rtic •	10	S. Spencer Ferree Emma	L. Good	Ling	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Hauth and Mental Hygiene. Itam 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Example are multiled at		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Re			Zip Code)
	1 and 2 Health am 27 ther tr	- 1		Seven Vall	Leys, PA	17360
ore	ot He fitan		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	0c. Location - City or	Town, State
Ĕ	Pages nent of ant: If its ury or o		### Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Peter's Cemetery May	17,2006	Seven Val	leys,PA 1736
Baltimore	permit. Pages 1 and Department of Health Important: If itam 27 any Injury or other tr once.	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	teiple Fur	neral Home	Inc.
_	205 2 2		V C I I I I I I I I I I I I I I I I I I	53 Main St		ock, PA 1732
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.	c or respiratory arre		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition ACLL+R MI+CAL VOGILICOI+	ation		Onset and Death
-18	/Medical		resulting in death) Due to (or as a consequence of):	CA 1010		(and (fact))
60	Examiner		Sequentially list conditions. b. Yuchwed Mo. I Ard M	uscle		72 hours
	ם ב	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Λ .		
V	ecute and trans	am	that initiated events	Harcho	N	
50,	sicien and burial-transit	0	Due to (or as a consequence of):			
8760	the the	dlcal	d			
9 x	that the death certific: ed by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			73 mi
Вох	attene for us	lan	In the past 12 months?		23d. Date of de Month	livery Day Year
o.	the de	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5 ☐ Other (specify)			
م ٔ	that t ed by detac		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
ds,	signed d be del	ğ	Chronic obstructive on On many disease	1 ☐ Yes	s 2 🗆 No 3 🗆 P	robably 4 Unknown
Ö	w requir been si should	ete	handsoidis	24a. Was an	045 146	Annual de la constanta
of Vital Records,	has has	Completed by	hy po-thyroidism	autopsy perform	prior to	utopsy findings available completion of cause of
a			pulmonary hypertension	1 Yes 2	No 1 ☐ Yes	2 □ No
<u>K</u>	Physician: this certific ral director,	Be	examiner? Hospital: A	ath (Check only one		
of	Phys r this ral di	. To	27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe hov	nce 6 Other (Spe	ocify)
O	ding th. Afte	ţ	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No			
Division	Attending ir death. ector: Atter by the fune	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stre	eet and Number or R	ural Route Number,
Ö	al or afte Dire	Certification:	4 Homicide building, etc. (Specify)	City or Town,	State)	
	spita hours inera y fille		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	e, and due to the car	use(s) and manner a	s stated.
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	urred at the time, da	te and place, and due	e to the cause(s)
	To the To the Comp	Z	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Mon	h, Day, Year)
			Clipble DCX P19180		WAY 1	3 2006
	16		36 Name and address of person who completed cause of death (Item 23a) (Type, Print)		7	
	10	1000		Baltimor	e, MO	21201
	Sta Registi		31. Date filed (Month, Day, Year) MAY 2 0 2006 32. Registrar's Signature			
			The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s			

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Physic		1. Decedent's Name (First, Middle, Last)	105				2. Date	of DeatMay	7 3, 200	
/Med Exami		a. Facily Name (If not institution, give st Bradford Oaks Nu:	reet and number)	Ctr.		n, or Location of	Death		c. County of Dea	
Funera Director		5. Social Security Number 6. Sex 249–34–4588	7. Age (In yrs. Ia M 2□F 78	st birthday) Yrs.	If Under 1 Ye Months Da			of Birth oth, Day, Year	7 0	thplace (State or Foreign ountry) th Carolina
yland		Usual Residence of Decedent 10a. State 10b. County		, Town or Lo	cation					10d. Inside City Limits
the Mar 28a-f st	Funeral Director	MD Prince Go	eorges Cli	nton	10f. Zip Cod	А		10a C	itizen of What C	1 A Yes 2 □ No
23a or	rai Di	6515 Northam Road			20748				S. A.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show say Injury or other traumatic event, the Madical Examiner must be multiled at once.	Þ	11. Marital Status 1 Never Married 2 A Married 3 Widowed 4 Divorced	 Was Decedent Ever in U.S Armed Forces? 1		Was Decedent f Yes, specify C 1 ☐ Yes 2 🔯	of Hispanic Origi cuban, Mexican, No Specity:	in? (Specify Yes Puerto Rican, e	or No- tc.)	14. Race - Ame Black, Whi Specify: B1	te. etc.
vithin 72 hours at ne. han "natural", or ne Medical Exem	Completed	15. Decedent's Educe (Specify only highest grade) Elementary/Secondary (0-12) 12th.	ation completed) College (1-4or 5+)	(Give life. l	dent's Usual Ockind of work do DO NOT use re Lenance	cupation ne during most tired) Engine	of working		Cind of Business	
ylallu 2 buld be filed wi Mental Hygien arked other th atic event, the	To Be Co	17. Father's Name (First, Middle, Last) Samuel Cox					s Name (First, I nheim Gr	Middle, Maidei Caves	n Sumame)	
d 2 shoulth and M th and M ?7 is mark traumati	-	19a. Informant's Name/Relationship (Typ			-	eet and Number am Road		-	or Town, State,	Zip Code)
Definition of your permit. Pages 1 and Department of Heel mportant: If Item 2 my Injury or other page.	P	Margaret Hines Gra 20a. Method of Disposition 1	20b. Pla	ace of Dispo metery, cren Zion	sition (Name or natory or other Cemete	place) ry Ma	Date ay 9,200	20c. L 16 F1c	ocation - City or rance,	S.Carolina
permit. Departm Imports any Inju		21. Signature of Funeral Service Licenses	ami	3	Name and Ad 831 Geo	dress of Facility rgia Av	Latne) enue, N	.W. Was	eral Ho sh.D.C.	20011
Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death. e cause on each line. ASPV		er the mode of	dying, such as c	ardiac or respira	itory arrest,		Approximate Interval Between Onset and Death
/Medica Examine		resulting in death)	Due to (or as a conseque					-		
cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	ence of):						
certificate be executed vding physicien and lise as the burial-transit	dicai	resulting in death) Last	Due to (or as a conseque	ence of):						
death death e atter	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of decent	death 3	Ectopic pregna Other (specify				23d. Date of de Month	livery Day Year
law requires that the as been signed by the 2 should be detached.	و	Part II. Other significant conditions cont	nbuting to death but not resul	lting in the u	nderlying cause	given in Part I.	236	Did tobacco	_	o the cause of death?
The lay	Completed							: Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
OI VILAI I Physician: Th this certificete ral director, pag	o Be (25. Was case referred to medical examiner?	ospital: 1 Inpatient 2 E	P/Outpation	it 3 DOA	0	of Death (Check		6 ☐Other (Spe	-41
dlng After	1 -	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. l	njury at Work? I □ Yes 2 □ N	28d. Des	cribe how inju		city)
DIVISION spitel or Attending ours after death. eral Director: After	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, str	eet, factory, offi	сө		ation (Street a or Town, Stat		ural Route Number,
To the Hospital or Attenwithin 24 hours after deat To the Funeral Director:	edical (29a. Certifier 1 X Certifying Physi (Check only one) 2 Medical Examin	ician: To the best of my know er: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred at the vestigation, in n	e time, date and ny opinion, death	place, and due occurred at the	to the cause(s	and manner as d place, and due	s stated. e to the cause(s)
5	W	29b. Signature and title of certifier	enl		29c. Lic D35	ense number 206			4, 200	
>		30. Name and address of person who cor William T. Tanner	npleted cause of death (Item	23a) (Type,	Print) l Livin	gston Ro	oad Ft.	Washi	ngton,	Md. 20744
S Regis	tate trar	31. Date filed (Month, Day, Year) MAY 0 9 201	32 Aegistrar's Signaty							

		1	For State Registrar	State of Marylan			t of Health and e of Death	l Mental	Hygien Reg. N	7 1111	6	16039
	ġ.		1. Decedent's Name (First, Middle, Last)			-		2. Date Mont	of Death	ay Ye	35	3. Time of Death
Phys			Viola Loretta Goud	2.77				May	6	2006		8:16 A ^M
/Me Exan	dica		4a. Facility Name (If not institution, give str			4b. City,	Town, or Location of De		4	c. County of D		
Exam	nine		11435 Maple View D			Wh	eaton			Montg	ome	rv
	-1		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year If Under 24 H	rs. 8. Date	of Birth th, Day, Yea		Birthpla	ce (State or Foreign
Funer Direct			578-03 - 2990	4 2 TXF 92	Yrs.	Months	Days Hours Mi	Sep.	24,19	13 M	Co <i>u</i> intr aryl	
(m -ax	3	-	Usual Residence of Decedent									
/lanc			10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					100	d. Inside City Limits
Man,		ğ,	Maryland Montgome	rsz	Wheato	าก						1 ☐ Yes 2 反 No
the 28a		Director	10e. Street and Number	<u> </u>	Mileave	10f. Zip	Code		10g. C	Citizen of What	t Countr	y?
as or	-		11435 Maple View D	rivo			20902			USA		
IL I 3-0030 within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-1 show then "neturel", or Items 23e or 28e-1 show		runerai		. Was Decedent Ever in U	.S. 13. V	Vas Dece	dent of Hispanic Origin?	(Specify Yes	or No-	14. Race - A		
fter of reference		5	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No			cify Cuban, Mexican, Pu	eno mican, et	C. <i>j</i>	Black, V	vnite, ei	IC.
hours af		2	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1	I □ Yes	2 No Specify:			Specify:	Wh	nite
2 hou		Completed	15. Decedent's Educa		16a. Deced	lent's Usu	al Occupation	und in a	165.	Kind of Busine		
nin 7.	1	ble	(Specify only highest grade Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	life. L	DO NOT u	rk done during most of v se retired)	vorking				
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Hyg other	9	a l	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, M	liddle, Maide	en <i>Sumame)</i>		
IZITICA Id be filk ental Hy ked oth ic event	-	0	William Franklin M	cNall			Netti	e Naom	i Cunt	ningham)	
thoul M Min mart	1	=	19a, Informant's Name/Relationship (Type		19b. Mailin	g Address	(Street and Number or					Code)
Mal d2sh thanc thanc 17 Is n			John M. Hood	Son	11/35	Maril	e View Driv	re Wh	eaton	.Maryla	ha	20902
DESITIMOTE, MISTYISTIC A 1 2 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23s or 28s-1 show many injury or other than many injury or other than "natural".	1	ŀ	John M. Weed 20a. Method of Disposition	20b. I	Place of Dispo	sition (Na	ne of	Date		Location - City		
iges it of or o	A		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Re		cemetery, cren klawn N		ial		1,000	NEW PORCE		12 EV
TIIT TIME Tant tant	4	1	' 4 □ Donation 5 □ Other (Specify)			P	ark May	10,20	06 Roy	ckville	,Ma	ryland
GAITIMOT Definit. Pages Department of I mportant: If It any injury or o	DC B		21. Signature of Funeral Service Licenses		Fra	ancis	d Address of Facility of J. Collins	Funer	al Hor	me, Inc		
0 00F	a	1	Jan 50	alle			versity Blv			r Sprin		D 20901 Approximate
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the dea cause on each line.	th. Do not ent	er the mod	ie of dying, such as card	liac or respira	tory arrest,			Interval Between Onset and Death
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/Medic			resulting in death)	Due to (or as a consec								
Examin	er _.		Commente the line and distance	Diabetes Me	11itus							
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uted		Ē	Cause (Disease or injury that initiated events c.									
Hecords, P.O. Box 68/60, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		Examiner	resulting in death) Last	Due to (or as a consec	quence of):						-	
8/60 ate be e hysiciar the buri		dical	d.									
ficati ficati phy s this		ed										
BOX 6 eath certific attending p		Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregn		Je				23d. Date of	deliver	у
BOX leath cert attendin		cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Feta 4 Pregnant at time of]Ectopic p] Other (s				Month	(Day Year
at the de by the atached		ys	9 Unknown	9□ Unknown								
S, T. Tes that igned by be deta		1 P	Part II. Other significant conditions cont	ributing to death but not re	sulting in the u	nderlying	cause given in Part I.	23e	Did tobacc	o use contribu	te to the	cause of death?
sign sign		p						I	1 🗌 Yes	2√2No 3[] Proba	bly 4 🗆 Unknown
Division of Vital Hecords, for Attending Physician: The law requires tater death. Director, After this certificate has been signed in by the timeral director, page 2 should be 9.		Completed						240	. Was an	24h War	e auton	sy findings available
Hec ne taw has t		du					·	-	autopsy performed?	prior	r to com	pletion of cause of
The t		Ö						1 🗆	Yes 2. ₩		Yes 2	P∰ No
Of Vital Prysician: The Physician: The ribis certificate and director, page		Be	25. Was case referred to medical examiner?					Death (Check				
Of \Physic this c		٥	TU TOS ZIZINO		ER/Outpatier	-					Specify)	
ng P fter t		ü	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?	28d. Des	cribe now in	jury occurred		
VISION Attending r death. ector: After		atle	2 Accident investigation			M	1 ☐ Yes 2 ☐ No					
Vis Per de Fecto	5	tif	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I building, etc. (Spec		eet, facto	y, office		ition (Street or Town, St		or Rural	Route Number,
Saft Digital		Certification;										
bour hour iners			29a. Certifier Certifying Phys	ician: To the best of my kn er: On the basis of examin	owledge, deat	h occurred	at the time, date and plants in my opinion, death a	ace, and due	to the cause	(s) and manne	er as sta	ited.
DIVISION (To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After completely filled in by the funeral		Medical	(Check only 2 Medical Examin	er: On the basis of examin and manner stated.	adon and/or in	vostigatio	i, iii iiiy opinion, death o	ocumen at the	ame, uale a	and place, and	- QU O 10	(00000(5)
To th To th		ž	29b. Signature and title of certifier		No		c. License number		29d. [Date signed (A	Aonth, E	Day, Year)
			> Offrance	kma	M.D	*	D-27660	0	Ма	y 8, 20	006	
6			30. Name and address of person who con	npleted cause of death (Ite	m 23a) (Type.	Print)			114	, , , , ,		
			Alpana Goswami, M.				ke #G100 I	Rockvi1	le. M	arvland	1 20	852
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign								
0-	ola victr		MAY n a 2006	he he	Some	12 8						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Sitter of Maryla Per Preparement of Health And Mental Hygiene?

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0437 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner "NONE" medical Center Saltimore Iniversity If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 1, 1948 If Under 1 Year Months Days 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Hours CONNECTICUT 1 X M 2 □ F 58 Yrs. 045-40-5126 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturet; or itema 23s or 28s-1 show say injuly or other traumetic event, it a Medical Examinat must be included at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Completed by Funeral Director OLNEY MONTGOMERY MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20832 U.S.A. 2906 CLOVERCREST WAY 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No ARMY If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Marned Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DEPM'T OF VETERANS AFF BUSINESS OPERATION LIAISON 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be FRANCES PAUL FRED GORFAIN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2906 CLOVERCREST WAY, OLNEY, MARYLAND JOSHUA E. GORFAIN/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State JUDEAN MEMORIAL GDNS 05/07/2006 OLNEY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses eny in EDWARD SAGEL FUNERAL DIRE 1091 ROCKVILLE PIKE, ROCK INC. MARYLAND 20852 Donald 23a. Part1. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Shot wand /Medical Oue to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): use as the burialthe attending physician Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ρ 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ed bluods 3 ☐ Probably 4 ☐Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐ Yes 2 ☐ No 2 N 1 ☐ Yes To the Hospital or Attending Physician; within 24 hours after death.
To the Funeral Director: After this certifica completely filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 es 2 No Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1936 - 28b. Time 1936 - 206 Injun 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injuny1209p 1 Natural 5 Pending self-inflicted gun shot wound 1 🗌 Yes investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Num er or Rural Route Number, City or Town, State) 4 Homicide Olney, me 2106 Clarer crest 1 I (Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 16536 MAY 5, 2006 30. Name of d address of person who are pleted cause of death (Item 23a) (Type, Print) lina HOTH 22 SOUTH GREEN ST, BALTIMORE, MD 31. Date filed (Month, Day, Year) State MAY 09 2006 Registrar

			1 - For State Registrar	State of M		d / Depa		t of H	ealth a			_	06	16041
	Physici /Medi		Decedent's Name (First, Middle, Last Gordon France)	cis Gamb							2. Date of Dea	Day	Year	3. Time of Death
1	Examir	ier	4a. Facility Name (If not institution, give Washington Co	unty Hosp	ital_		Ha	gers				4c. County Was	hing	
L	Funeral Director		5. Social Security Number 6. S 219-32-3780	ex 7. A	ge (In yrs. 70	last birthday) Yrs.	If Unde Months		If Under 2 Hours	Min.	8. Date of Birth (Month, Day April 1	, 1936	Cou	place (State or Foreign ntry) y l and
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23s or 28s-f show ther, the Mudical Exercities mast be notified at	Director	10a. State 10b. County West Virginia Berke	eley	10c. Cit	y, Town or Lo	lling		ers					1 ☐ Yes ZXXNo
	ath with the 23a or 2	erai Dire	10e. Street and Number 41 Muse Stree	12. Was Deceden	. Charles II	6 42	10f. Zij	254		-i-2 (C		0g. Citizen of \	US	,
9800	ours after de rel', or item Exeminer	d by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4	Armed Forces 1. Was Deceden Armed Forces 1. Wes 2 If Yes, Give Year or Dates	? No 19	22-	was Dece If Yes, spe		spanic Origin, Mexican Specify:	in r (Spe , Puerto	ecify Yes or No- Rican, etc.)		k, White,	
21215-0036	within 72 h jiene. r then "netu the Mudice.	Completed by Funeral	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or	5+)		dent's Usu kind of wo DO NOT u	ork done d se retired,	uring most)	of worki	ng	16b. Kind of Bu		Yard
Maryland 2	uid be filed Mental Hygi arked other atic event, it	To Be C	17. Father's Name (First, Middle, Last) William Franci	s Gamber			11917				(First, Middle, I			
Baltimore, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show moortant: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at ADEs.		19a. Informant's Name/Relationship (7) Sandra Sowers — 20a. Method of Disposition XXBurial 2 □Cremation 3 □ 4 □Denation 5 □Other (Specific	Friend Removal from State	, ,		Muse osition (Na matory or o	Stre	et F	alli	ate	rs, West 20c. Location -	Vir City or To	ginia 25419
Balti	permit. Pag Department Important: I any injury o		21 Signature of uneral Septice Lices	See L		9	sbort 25 S.	e ^{Ad} Fe Con	nefrail ococh	Home	ne, P.A. ne St. W	illiams		21795 Maryland
1	Physician /Medical Examiner	700	23a. Part Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. PC - 1 Due to (or a	s a conseq	uence of):	9 ~ D	AL	INI	= M.	ACTIO,			Approximate Interval Between Onset and Death
,160,	_	cai Examiner	Sequentially list cumultions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a d.	s a conseq	uence of):) SEC	4EA	NT	נז נו	(5N15			PAIC RECIPION
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	I death 3	□Ectopic p □ Other (s)					23d. Dai	e of delive	ery Day Year
	v requires that been signed t should be det	þ	Part II. Other significant conditions of	ontributing to death	but not resi	ulting in the u	nderlying (ause give	n in Part I.					he cause of death? pably 4 •Unknown
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	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	ledical	(Check only 2 Medical Exan	ysician: To the bes niner: On the basis and manner s	of examina	wledge, deat tion and/or in	vestigation	ı, in my op	inion, deat	d place, a h occurre	ed at the time, d	ate and place, a	and due to	o the cause(s)
),		2	29b. Signature and title of certifier	Ilan,	n D		J 29	c. License	number	1 0		9d. Date signed		
0	· 6x		30. Name and address of person who		death (Item	23a) (Type,		~	ST. I	146	= NSTDW			740
Reg	Sta Regist		31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	ture	ande)		.,					

State of Maryland / Department of Health and Mental Hygiene? For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 0720M Beula Florence Glotfelty /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death
ALLEGAN 4b. City, Town, or Location of Death Examiner SOCRED HEART HOSPITAL CUMBERLAND | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov • 19 | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** , 1928 Maryland 1 ☐ M 2 🔀 F 212-38-6155 77 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant if Item 27 is marked other then "natural", or Items 23s or 28s-f ehow 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Garrett Grantsville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21536 15966 Bittinger Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Nilled Poices: 1 ☐ Yes 2 🐼 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: ģ 3 Widowed 4 □ Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Textiles 10 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be Ethel Platter Harry Durst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3059 Hare Hollow Rd., Grantsville, MD 21536 <u>Marlene L. Beachy/Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 1
Department of H
Important: If ite
ony injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May 5,2006 Bittinger, MD Bittinger Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Newman Funeral Homes, P.A. elmoral P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEVERE Immediate Cause (Final CHRONIC OBSTRUCTURLUNG DISEAS CO) **Physician** disease or condition resulting in death) /Medical RESPIRATORY Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner ed by the ettending physicien and detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐ Live birth 2☐ Fetal dea
4☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but pot resulting in the underlying cause given in Part I.

CARAWARY SPTERY DISEASE WILL COMMAN, been signed 23e. Did tobacco use contribute to the cause of death? ģ Our PASS 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificete 1 Yes 2 No 1 Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident illed in by the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

30 Name and address of person who completed cause of death (Nem 23a) (Type, Print)

3 2006

CHANGIMD

32. Registrar's Signature

DATUENINA

31. Date filed (Month, Day, Year)

		1 - State Registrar		artment of He tificate of D		Re	g. No UU6	16043
	sician	Decedent's Name (First, Middle, Last) EVELYN M	GATLING			2. Date of Death Month MAY	Day Year 2006	3. Time of Death 11:20 A ^M
	edical miner	4a. Facility Name (If not institution, give street and number) 7634 NORMADY ROAD		4b. City, Town, or Lo			4c. County of De	ath
Funer Direct	_		'In yrs. last birthday) Yrs.	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	PRINCE G	rthplace (State or Foreign country)
ס		Usual Residence of Decedent 10a. State 10b. County 1	Oc. City, Town or Loc				g. Citizen of What C	SHINGTON, DC 10d. Inside City Limits 1 Yes 2 No
OUSO hours after tural', or its	eted by Funeral D	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	16a. Deced	lent's Usual Occupation	Mexican, Puerto Specify:	Rican, etc.)	U.S.A. 14. Race - Am Black, Wh Specify:]	ite, etc. BLACK
C C L C 1 S- filed within 72 Hygiene. ther than "na	Completed	Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last)	life. D	N. ASSISTA	NT		GOVERNMEN	NT
Maryland d 2 should be file th and Mental Hy 7 is marked oth traumatic even	To Be	ROBERT PITTS	40b M 77		EVELYN	A. GATL	ING	
E BE E		19a. Informant's Name/Relationship (Type, Print) ROY KELLY JONES JR./SON 20a. Method of Disposition	1002 20b. Place of Dispos	g Address (Street and 2 SPRING E sition (Name of natory or other place)	PLACE DR	IVE HOUS	,	s 77070
Dall(Imore permit. Pages 1 Department of H Important: If ite	once.	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Riverdal	Le Cremato: Name and Address of		_	RIVERDALE	
hologician and physician and sthe burial-transit	icai Examiner	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition or cause). Due to (or as a condition or cause). Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition or cause).	erotic Cor consequence of):	er the mode of dying, s		-	st.	Approximate Interval Between Onset and Death
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The lar	e e	Diabetes Mellitus				24a. Was an autopsy performs	prior to death?	utopsy findings available completion of cause of
Of VICAL Physician: The This certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ☐ ER/Outpatient	Othor		(Check only one)		
Afte	ation: T	27. Manner of Death 1 Stantural 5 Pending 2 Accident investigation		28c. Injury at Work?		8d. Describe how	ce 6 Other (Speringly occurred	(city)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury building, etc. (- At home, farm, stre Specity)	et, factory, office	2	8f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
he Hosp. in 24 hou he Funer Dietely fills	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of n 2 Medical Examiner: On the basis of example and manner stated	amination and/or inve	occurred at the time, estigation, in my opinio	date and place, a on, death occurre	nd due to the cau d at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
To the Within Comp	Ň	29b. Signature and title of certifier	/ Un	29c. License nu D0058		290	May 3,	
2(4)		30. Name and address of person who completed cause of deat Suresh Muttath M.D. 4203 C)ueensburv	Road Hyat	tsville	. Marvla		
	State istrar	31. Date filed (Month, Day, Year) MAY 0 5 2006	Signature	E)	and the second terminate			

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Jose Armando Gomez

		1- For State Registrar	Cei	rtificate of L	Death		., g.cc	teg. No. 2	005	160
Physici Medical Exam		Decedent's Name (First, Middle, Last) Jose Armando Gamez					Date of Dea Month	ath Day Yea	or 1	Time of Death
		4a. Facility Name (if not institution, give street and	I number)	4b	. City, Town, o	Location of Dea	May 12, 2	4c. County		
		8119 14th Avenue Apartment 101	17.4.		Hyattsville				George's	
Funeral Director		5. Social Security Number 6. Sex None 1 M 2	7. Age (In yrs. Ia	ast birthday) Yrs.	Months Day			rth(MM/DD/YYYY /1966	7) 9. Birthplai Foreign Country	ce (State or Hondura
any		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	1				10d	d. Inside City Limit
Aaryland 28a-f show any Lat once.	'n	Maryland Prince George	's Hy	attsvil	le				1 [X Yes 2 N
h the Maryland 3a or 28a-f sho	Director	10e. Street and Number 8119 14th Avenue #101	· · · · · · · · · · · · · · · · · · ·	1	10f. Zip Code 207	02	1	0g. Citizen of Wh	nat Country?	
ith the 23a oi notifie									luras	
eath w items	Funera	1 X Never Married 2 Married Armed	Decedent Ever in U. d Forces? s 2 X No			spanic Origin? (\$ n, Mexican, Puerl	Specify Yes or No to Rican, etc.)	14. Race White	- American li e, etc.	ndian, Black,
after d al", or	by Fu	3 Widowed 4 Divorced If Yes, Give		1X Y	es 2 No	specify: Ho	nduran	Specify:	White	e
hours 'natur Exami		15. Decedent's Education (Specify only highest of		16a. Decedent's during mos		tion (Give kind of DO NOT use re		16b. Kind of Bu	siness/Indus	try
36 hin 72 e. than '	Completed	Elementary/Secondary (0-12) College 1	e (1-4 or 5+)	None				None		
21215-0036 wld be filed within 72 h Mental Hygiene. marked other than "n c event, the Medical E		17. Father's Name (First, Middle, Last)		1.01.0	1			Maiden Surname	,	
2121 uld be fil Mental H marked c event, i	Be c	Francisco Gamez 19a. Informant's Name/Relationship (Type, Print)		I was as a				Gutierr ———		
O # 5 2 2 1	To	Nixon Martinez/cousin		1682 Ro	ogress (Streets)	et and Number or Court	Rural Route Nur	nber, City or Tow	n, State, Zip (Code)
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Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation 3 Remova 4 Donation 5 Other Specify:	4	mily Cem		5/	15/2006	Hondu	ıras	
Baltimo permit. Page Department (Important: injury or off		21. Signature of Funeral Service Licensee		22. Nan	ne and Address	s of Facility 🖟 🕡	H. Facon	Funeral		
Physician		23a. Part I. Enter the disease, or complications that	of caused the death	361 344	7 14th	Street,	N.W. Wa	sh., D.(
/Medical	1	failure. List only one cause on each line.	c arrhythmi		mode of dying,	Such as cardiac	or respiratory arr	est, shock, of flee		proximate Interva etween Onset and Death
Examiner		or condition resulting in death) Due to (or a	s a consequence of	r):						
	ē	Sequentially list conditions,	ry artery as s a consequence of						_	
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8760, ifficate be ex ng physician is the burial	/Mec	IF FEMALE: 23c. If ye	s, outcome of pregr	nancy				23d Date of	delivery	
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Box ne death c the atten	Physicia		known							
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certified the death certificate has been signed by the attending Physicians that the property of the physician has been signed by the attending the fuller in by the funeral director, page 2 should be detached for use a	ð	Part II. Other significant conditions contributing	g to death but not re	sulting in the und	erlying cause g	given in Part I.		bacco use contrib		ause of death? 4 Unknown
ords, v require s been sig	Completed						24a. Was a			findings available
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of Vital Records, ng Physician: The law require this certificate has been si meral director, page 2 should b	Be Co	25. Was case referred to medical			26.Place	of Death (Check	1 Yes :	2 No 1	✓ Yes	2 No
Vita hysici this ca	To B	examiner? 1 Ves 2 No Hospital. 1		ER/Outpatient 3	DOA	Other Nursi	ng Home 5	Residence 6	Other: Scen	ne
n of ding Pl h After funera	Ë	1 X Natural 5 X n (Mo	ite of Injury nth, Day,Year)	28b. Time of Injur		ry at Work? res 2 No	28d. Describe h	now injury occurre	d	
Division tal or Attendi ts after death al Director: A led in by the fu	icati	2 Accident Investigation 28e. Pl	ace of Injury - At ho	me. farm. street. f			28f Location (S	treet and Number	r or Pural Pa	uto Numbor City
Divi spital or tours after neral Dir filled in	Certification:	3 Suicide 6 Could not be determined (Special					or Town, Si		or Rural Ru	ate Number, City
		29a Certifier 1 Certifying Physician: To the b	pest of my knowledg	e, death occurred	at the time, da	ate and place, and	d due to the cause	e(s) and manner a	as started	
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the bas and manne 29b. Signature and title of certifier	is of examination an r stated.	nd/or investigation	, in my opinion 29c. Licens		at the time, date a			_ ` '
		De STATE VI	010-		O.C.I			29d. Date signed May 13, 200		ıy, Year)
10		30. Name and address of person with completed ca	ause of death (Item :	23a)				, .5, 250		
- (H)	Н	Carol Allan, MD Assistant Medica		111 Penn Str	eet, Baltim	ore, MD 2120)1			

State 31. Date filed (Month, Day, Year)
Registrar MAY 1 5 200 MAY 1 5 2006

			1 - For State Registrar	State of Maryland		rtment of H tificate of I			iene 200	6 16045
	Physici /Medi		Decedent's Name (First, Middle, Last) Susan Linda	Goldsborou	ıgh			2. Date of Dea Month May	_	3. Time of Death 9:20A M
	Examir		4a. Facility Name (If not institution, give to 13217 Linvery	Place		4b. City, Town, or Newbu	ırg		4c. County of E	
	Funeral Director		5. Social Security Number 218-56-9934 Usual Residence of Decedent	7. Age (In yrs. last	Yrs.	Months Days	If Under 24 Hrs Hours Min J	8. Date of Birth (Month, Day) anuary	19,1950	Birthplace (State or Foreign Country) Maryland
	Maryland a-f ahow	ctor	MD 10b. County Charle	10c. City, T	ewbu					10d. Inside City Limits 1 ☐ Yes 2 No
	ath with the	rai Director	10e. Street and Number 13217 Linvery			10f. Zip Code 2066			0g. Citizen of Wha	•
036	72 hours after death with the Maryland *natural', or itama 23a or 28a-f ahow idical Examinar must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Dates:		/as Decedent of Hi Yes, specify Cuba ☐ Yes 2XNo	spanic Origin? (\$ n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		American Indian, Vhite, etc. White
21215-0036	within ene. then	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 1 e completed) College (1-4or 5+)	(Give k	ent's Usual Occupa and of work done of O NOT use retired Homema	furing most of wo	rking	16b. Kind of Busine	ess/Industry
Maryland 2	s 1 and 2 should be filed if Health and Mental Hygi Itam 27 ia markad other other traumatic avant,	To Be C	17. Father's Name (First, Middle, Last) Thomas M. Lower				Mary A			
	l and 2 shu fealth and im 27 is m		19a. Informant's Name/Relationship (Ty, Frank Goldsboro	ough/Husband	P.0	. Box 2	nd Number or R	burg, MD	20664	
altimore,	t. Page rtment o rtant: If sjury or		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □R 4 □ Donation 5 □ Other (Specify)	emoval from State Char	les les		1 Gar.	5/8/06		dtown,MD
Bal	Dermi Depa Impo any is		21. Signatore of Funeral Service License 23a. Part1. Enter the disease, or compli	rula	2	11 SE.	Mary's	FUNERAL Ave. L.	a Plata	P.A. ,MD 20646
A PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PAR	Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	er	97	Ova	•		Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions,	Oue to (or as a consequent				/		
68760,	ficate be executed physician and s the burial-transit	edical Examin	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):					
P.O. Box 68	The law requires that the death certifica tis has been signed by the atlending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
	w requires that been signed by should be deta	۵	Part II. Other significant conditions con	tributing to death but not resulting	g in the und	derlying cause give	n in Part I.			e to the cause of death?
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3	siciar certif irecto	o Be	25. Was case referred to medical examiner?	ospital:		3CT DOA Othe		ath Check only one		
on of	Attending Physician: r death. ector: After this certifics by the funeral director.	itlon: To	27. Manner of Death 1 Natural 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Time of Injury	28c. Injury Work	4 🗀 INUISING F	fome 5 Resider 28d, Describe ho		pecily)
Divis	후류후	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stree	et, factory, office		28f. Location (Str. City or Town,	eet and Number or State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral is completely filled	edical	29a. Certifier (Check only one) Check only one)	ician: To the best of my knowled er: On the basis of examination and manner stated.	ge, death o and/or inve	occurred at the time estigation, in my op	e, date and place inion, death occu	, and due to the ca irred at the time, da	use(s) and manner te and place, and d	as stated. due to the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier ### ### ############################	MMath	<u></u>	29c. License	number 3.9	29	d. Date signed (Mo	onth, Day, Year)
Ci	BID		30. Name and address of person who con Krishan Mathur	mpleted cause of death (Item 23a , M.D. P.O. B	ox 1	^{rint)} 703 La	Plata,	MD 20646	5	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Redistrar's Signature	x A	berte				

ysicia		riogiotia.				061	rtment of l Ofdinb tificate of	Dealli	2. Date of Deal		20	3. Time of Death
		1. Decedent's Name (First	_		7	_			Month	Day	Year	
ledic	al -	Joseph 4a. Facility Name (If not in.	Rober		Gregory	<u> </u>	4h City Town o	r Location of Dea	May 1	4c. County	of Death	3:45 P *
amin	er	Dennett Roa				om e		land			Garre	tt
eral		5. Social Security Number		Sex		rs. last birthday)	If Under 1 Year					place (State or Foreig
ctor		220-32-4023	3	1 X M 2□ F	68	Yrs.	Months Days	Hours Will	July 25	1937	Mary	land
	-	Usual Residence of Deced	dent County		10c	City, Town or Lo	cation				1	10d. Inside City Limits
event, the Nedical Exerciner must be notified at	5	MD	Garı	• • + +			ain Lake	Dark				1 X Yes 2 ☐ No
H H	Director	10e. Street and Number	Gall			Moune	10f. Zip Code	TAIK	1	0g. Citizen of	What Cour	ntry?
2	흐	607 N St.,	Ant	27				21550			USA	
	Funeral	11. Marital Status		12. Was Dec	cedent Ever in	U.S. 13.	Was Decedent of H f Yes, specify Cub	lispanic Origin? (Specify Yes or No-		ce - Americ	can Indian,
	by Fur	1 Never Married 2		Armed F 1 ☐ Yes If Yes, G Year or i	2 No		1 Yes, specify Cub 1 ☐ Yes 2 🖾 No		ito nicali, etc.)	Specif		
		15. D	ecedent's E	ducation	1)		dent's Usual Occup			16b. Kind of B	usiness/in	dustry
	ple	Elementary/Secondary		rade completed, College	(1-4or 5+)	life.	DO NOT use retire	d)	,,,,,,,,			
	Completed	7				Со	al Miner		(5) A 40 (11)	Coal I		g
	Be	17. Father's Name (First,			"****	,		Linda	me (First, Middle, i Louis		me) Oates	
	ဥ	Joseph	Edwar		Gregory		- Address (Ctrop)		lural Route Number			
Í		19a. Informant's Name/Re Hazel G. Gr				1			Mountain			
once.	1	20a. Method of Disposition		7 11220	201	o. Place of Dispo	sition (Name of	T		20c. Location		
		1 X Burial 2 ☐ Crer	nation 3 (n State N		natory or other pla H 111 C em		4/2006	Elk Ga	rden.	WV
		' 4 ☐ Donation 5 ☐ C					2. Name and Addre			Secon		
ouc		Bradle			er DVR				ome Oakla	nd, MD	215	50
		23a, Part1. Enter the disc	ease, or cor	nplications that	caused the d	eath. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory arr	est,		Approximate Interval Between
J		shock, or heart failu Immediate Cause (Final	re. List on	^	. 1	1000	1 1	narco	031		13	Onset and Death
		disease or condition resulting in death)		d.	Orasa cons	noguonce of\:						- 3
1			- 1	(1	2						
ı	-	and the state of the state of		h -	nrone	6 0657	fructive	puln	nonory	diseo.	se 1	Dyears
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State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 **Physician** Emma Mary Hawkins 05 2006 1:20pM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4924 Roller Road Manchester Carroll If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 214-18-0454 84 Director 02-06-1922 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits itam 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at MD Carroll Manchester 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4924 Roller Road 21102 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Peges 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. ant: if itsm 27 ie marked other then "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Movies 12 Cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James McCubbin Eleanor Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4924 Roller Rd., Manchester, Md 21102 Sharon Holmes - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition , = p 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Pege Department of Important: if eny injury or once. Carroll Cremation 05-06-06 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility MO0550 934 S. Main St., Hampstead, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG ANCER Physician 6 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Day 4□Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, HZPERTENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed ATRIAL FIBRUATION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed HYPOTHYROIDISM 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home SKResidence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 293 Cartifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ATTENDINE WJL D21155 PHYSICIAN 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 904 WASHINGTON RD WESTAWN STEP ARTHUR LRUDO, MD 31. Date filed (Month, Day, Year) 32. Resstrar's Signature State MAY 08 Registrar 2006

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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with fine Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28e-1 show any injury on the promitte event, the Medical Examination of the notified at once.		21. Signature of Funeral Service Licer		1	F-24	2_Name	and Addres	spot Faquit				me Inc.		. Sarri	ııa
ñ	permi Depar Impor eny ir		Mein Stiles										r Sprir		20	901
St.			23a. Rath. Enter the disease, or com shock, or heart failure. List only	pfications that car	used the deat	th. Do not ent	ter the m	ode of dyin	g, such as	cardiac o	r respiratory	arrest,		App	roximat rval Bet	e ween
	Physician		fmmediate Cause (Finaf											Ons	et and I	Death
	/Medical		disease or condition resulting in death)	a. Sepsis Due to (o	as a conseq									_		
	Examiner		Convention by list one ditions	_{b.} Aspira	tion P	neumon	ia									
×		je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ras a conseq											
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c												
ő,	e exection a		resulting in death) cast	Due to (o	ras a conseq	(uence of):										
8760,		dical	•	d										-		
9 ×	The law requires that the death certific ate has been signed by the attending pl page 2 should be detached for use as i	/Me	IF FEMALE:	23c. If yes, outco	ome of oregon	ancy										
Вох	atteneration	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live bir	h 2 ∏ Feta ntattime of c	afdeath 3	Ectopic Other	pregnancy					23d. Date of Month	Day	À	Year
P.O.	he de	ysic	1 Yes 2 No 9 Unknown	9 Unknov		Jean J	_ Other (specify)								
مز	res that the de igned by the a be detached f	'Ph	Part II. Other significant conditions of	contributing to dea	th but not res	ulting in the u	inderlying	cause give	en in Part I.		23e. Did	tobacc	o use contribut	e to the car	use of d	Jeath?
Division of Vital Records,	uires sign Id be	d by	Malnutrition, Hy	pertensi	on, Ar	terios	cler	otic	Vascu	ılar	1 🗆	Yes	2 No 3	Probably	4 🗀 🤇	Jnknown
00	w require	Completed	Disease, Comfort	Cama							24a. Wa	s an	24b. Were	autopsy fi	ndinos	available
Be	The lav	gmc	_bisease, comitoit	Care							auto	opsy ormed?	prior deati	to completi	ion of c	ause of
g		e C	25. Was case referred to medical						26 Place	of Doath	(Check only	201	Vo 1 1 1	/es 2□	No	
5	Physicien: rathis certificanal director,	To B	examiner? 1 ☐ Yes 2(3)XNo	Hospital:	patient 2	ER/Outpatier	nt 3 🗆 I	OCA Othe	0.5				6 □Other (5	Specify)		
O	g Phy er this		27. Manner of Death	28a. Date of		28b. Time o		28c. Injury	/ at				jury occurred	poony		
<u>0</u>	Attending in death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation		(Uay (Gai)	Injury	М		Yes 2 1	No						
Vis	of or Attendated after death Director: /	tific	3 Suicide 6 Could not b	288. Place 0	f Injury - At h	ome, farm, sti	reet, fact	ry, office		- 2	28f. Location City or To		and Number o	<i>Rural R</i> ou	ite Num	ber,
Ō	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:		30110111	y, [<i>Dpoon</i>	.,					J., G. 10	, 010	/			
	Hospitel 24 hours a Funerel I	edical	29a. Certifier 1 Certifying Pt (Check only 2 Medical Exam	nysician: To the base	est of my kno	owledge, deat	h occurre	d at the tim	ne, date and pinion, deal	d place, a	and due to the	cause , date a	(s) and manne and place, and	r as stated. due to the o	cause(s	.)
	To the h within 24 To the F complete	Med	one) 29b. Signature a /C title of certifier	and manne	r stated.			9c. License					Date signed (M			-
	To To			Moun	dan			D533				c.34. L		5, 2		
•	12			<u>·</u>			Determinant	2333					May	3, 2		
	•		30. Name and address of person who Shyamsundar Raja:		of death (fter 9801	T 23a) (Type, Georg	ia A	venue	, #11	.7, S	ilver	Spr	ing, MD	2090	2	
100	Sta	te.	31. Date filed (Month, Day, Year)	A. Re	gistrar's Signa	ature /	AP -									
2.3	Regist		MAY 0 9 20	16 Km.	H.	200	de									

		1- For State of Maryland / Depa	rtment of Health and N tificate of Death	lental Hygien Reg. N	2000 10010
	-	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Physic	ian	D 1 . W.11 W		Month Da	2006 6:02 A
_/Med		Robert Hill Haynes 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May 6	c. County of Death
Exam	iner			1	fam to a many
		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Silver Spring If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Iontgomery 9. Birthplace (State or Foreign
Funera		11 M 2□F Yrs.	Months Days Hours Min.	(Month, Day, Year	r) Country)
Directo		578-09-8539 81 Usual Residence of Decedent		Oct.3, 19	24 Washington, DC
pur *		10a. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits
aryli	5				1 ☐ Yes 2 反 No
% 2.	S	Maryland Montgomery Silver S	Spring 10f. Zip Code	100.0	itizen of What Country?
ith t	Directo	10e. Street and Number	Tot. Zip Code	109.0	mizer of writer odding?
death with the Maryland me 23a or 28a-f ehow r must be notified at	<u>@</u>	205 Northmoor Drive	20901	1-7 V N -	USA
ep .	Funeral	Armed Forces?	Vas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puent	Rican, etc.)	14. Race - American Indian, Black, White, etc.
or It		1 Never Married 2 Married 1 Yes 2 No	☐ Yes 2☑ No Specify:		Specify:
suno	l by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW TT			White
72 h	ompleted	15. Decedent's Education 16a. Decedent's Education (Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of work	ding 16b.	Kind of Business/Industry
P. C.	횰	Elementary/Secondary (0-12) College (1-4or 5+)	OO NOT use retired)		
d wil	2	4 FBI A			<u>Enforcement</u>
be filled with ital Hygiene od other the	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maide	n Sumame)
lenta ked ked	일	Howard Haynes	Cather	ine Guthr	ie
should h	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	g Address (Street and Number or Ru	ral Route Number, City	or Town, State, Zip Code)
is 1 and 2 should be filed within 72 hours efter death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "naturel", or Iteme 23a or 28a-f show other treumatic avent, the Medical Examinar must be notified at		Harriett Mildred Haynes Wife 205 N	Torthmoor Drive	Silver Spri	ng Maryland 20901
Hea Hea		20a Method of Disposition 20b. Place of Dispo	sition (Name of		Location - City or Town, State
Peges nent of l		1 M Burial 2 Cremation 3 CHemoval from State Cate of F	natory or other place) Ieaven		
tant July		4 Donation 5 Other (Specify)	Cemetery May	10,2006 Sil	ver Spring, MD
permit. Peges Depertment of Important: If it		Fra	ancis J. Collins 1	Funeral Hom	ne, Inc.
4059			University Blvd		
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
Physician	,	Immediate Cause (Final			Onset and Death one day
/Medica		disease or condition resulting in death) a. Myocardial Infarc	LIOII		One day
Examine	r				ton Hoors
	ē	Sequentially list conditions, if any, leading to immediate b. <u>Hyperlipidema</u> Dua to (or as a consequence of).			ten years
led Isit	듣	cause. Enter Underlying Cause (Disease or injury			
and I-tran	Examin	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
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certificate be executed ading physicien and use as the burial-transit	dicai	d			
eath certifici ettending pl	Σ	IF FEMALE:			
th ce tend	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy		23d. Date of delivery Month Day Year
0 0	200	1 Pres 2 No 9 Unknown	Other (specify)		
at the de by the	ڠ	9 Unknown			
2 2 2	y y	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
luire n sig				1 ☐ Yes	2 No 3 Probably 4 ₩Unknown
w require been sig should b	Completed	Hypertension		24a. Was an	24b. Were autopsy findings available prior to completion of cause of
e lav	2			autopsy performed?	death?
: The cete h	ပိ			1 ☐ Yes 2 🙀	No 1 ☐ Yes 2 🙀 No
rsiclan: The law s certificete hes t director, page 2 s	9	examiner?	Other	th Check only one	
A .2 0	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatien		ome 5 Residence	
ding Ph h. Alter th funeral			f 28c. Injury at Work?	28d. Describe how in	jury occurred
death. ctor: Al	atle	2 Accident investigation	M 1 Yes 2 No		
or Attendent efter death Director:	=	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number,
2 2 2 2	Certification:	building, etc. (Specify)		2., 0	117
apital or lours eften nerel Dir filled in			h occurred at the time, date and place	, and due to the cause	(s) and manner as stated.
Fur Fur	leglos	(Check only 2 Medical Examiner: On the basis of examination and/or in one)	vestigation, in my opinion, death occu	rred at the time, date a	nd place, and due to the cause(s)
To the Hospital within 24 hours e To the Funeral E completely filled	Me	29h Signature and #18e of certifier	29c. License number		Date signed (Month, Day, Year)
F ¥ F 8		1 1000000	100001		5/10/0G
1211		- GRUSHUNG YOU'S	NON DO!		010100
1		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	D. 1/20 000	THE TAX STORY DAY
		HOBYN D. YNDERSON 10801 LOC	KWOOD DRIVE >	LVEKSPK	5/6/06 4NG-ND #505 209
	State	31. Date filed (Month, Day, Year) 32. Begistrar's Signature	Casti)		
Regi	strar	WITH U Y ZUUD A MARKET SE SE			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 tem 5 per fh 9856 6-7-06 yt. State of Maryland? Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL 23, Day 2006 **Physician** SIDNEY M. HAIS 9:55 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY BETHESDA SUBURBAN HOSPITAL 5. Social ecurity Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F WASHINGTON, DC 518-14-7128 Vrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other then "neturel", or Iteme 23s or 28s-f ehow 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director MD MONTGOMERY **BETHESDA** 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 20814 4400 EAST WEST HIGHWAY U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑Yes 2 □ No If Yes Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1942–46 WHITE 1 ☐ Yes 21X No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ENTREPRENEUR REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOSEPH HAIS IDA FLAX 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ALAN HAIS-NEPHEW 5135 FAIRGLEN LANE CHEVY CHASE, MD 20815 nt of Health a : If item 27 is or other tre 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of important: If eny injury or pance. King David Memorial 4/26/2006 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, Va 21. Signature of Funeral Service Licensee 22. NDANZANSKY FGOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE ROCKVILLE, MD 20852 at June 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consecuence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit sate has been signed by the attending physicien and page 2 should be detached tor use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate hes performed? 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 📉 No Atter thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitar ... within 24 hours after death. To the Funeral Director: After To the Funeral Director to the fur 5 Pending 1 K Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check unity one) title of certifier 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D56652 MAY 2, 2006 M 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER DRIVE ROCKVILLE, MD 20850 MATTEW POFFENROTH 31. Date filed (Month, Day, Year)
MAY 0 9 2006 32. Angistrar's Signature State

Registrar

			For State Registrar	State of M	laryland /	•	artment of H		Mental Hy	giene Reg. No. 20	06	16052
			Decedent's Name (First, Middle, La	st)					2. Date of De	ath		3. Time of Death
П	Physici	an	WILLIAM MASON	HUTZELI					Month	Day	Year	8:30 A M
	/Medic		4a. Facility Name (If not institution, give				4b. City. Town. o	or Location of Dea		4c. County	of Death	07-011
1	Examin	er						AGERSTOW			INGT()M
			WASHINGTON COUNT 5. Social Security Number 6.5		ge (In yrs. last b	oirthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Birt	h		
н	Funeral Director			1 ⊠ M 2□F	79	Yrs.	Months Days	Hours Mir	OCT. 21	1926	Court M A I	lace (State or Foreign stry) RYLAND
		}	Usual Residence of Decedent		13			1	001. 21	1, 1,20	11/11	CTD/MID
	/land		10a. State 10b. County		10c. City, To	wn or Lo	cation				1	0d. Inside City Limits
	Man	ţō	MARYLAND WASHIN	GTON			HAGI	ERSTOWN				1⊠Yes 2□No
	288 po	Director	10e. Street and Number	01011			10f. Zip Code			10g. Citizen of V	What Coun	itry?
	deeth with the Maryland		333 MILL STREET					21740			U.S.	A .
	deett	era	11. Marital Status	12. Was Decedent		13. \	Was Decedent of F	lispanic Origin? (Specify Yes or No	- 14. Rac	e - Americ	an Indian,
20	in the second	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces	No 1952−	. '	f Yes, specify Cub		irto Hican, etc.)		ck, White,	etc.
8	hours after tural', or ite	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1954		1 □ Yes 2 😾 No	Specify:		Specify	′: W	HITE
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2	within 72 ene. than "nat he Medic	ple	Elementary/Secondary (0-12)	Coflege (1-4or	5+)	life. I	OO NOT use retire	d)	UI KIII Y			
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2	be fled within 72 hours after deeth with the Marylan Hygiene. Hygiene dother than "natural", or iteme 23a or 28a-f show do ther than "natural", or iteme must be notified at event, the Madical Examinar must be notified at	Be (17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Maiden Suman	ne)	
<u>a</u>		2	HARRY CALVIN HUTZ	ELL				GERTRUD	E LINE			
Maryland	2 should and Mer is marke		19a. Informant's Name/Relationship	,, ,			-		Rural Route Numbe			
	2552		KATHY M. BEITTEL/	DAUGHTER		2137	4 MT. LEI	NA ROAD,	BOONSBOE	RO, MARY	LAND	21713
altimore,	es 1 a of Hea of Hea r othe		20a. Method of Disposition	Damaual from State	camai	of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Location -	City or To	wn, State
Ĕ	Page nent int: if		1 △ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Denation 5 ☐ Other (Spec		•		CEMETERY	4	2/2006	BOONSBO	RO, N	IARYLAND
a ====================================	permit. Pag Department Important: eny Injury once.		21. Signature of Pyfleral Service Lice				. Name and Addre	ss of Facility	_	d Natio		
m	permit. Pages 1 Department of P Important: if its eny Injury or ot once.		Town May	Paul	M. Dear	$\mathbf{n} \mid \mathbf{B}$	AST FUNER	RAL HOME		oro, Mar		
Ť			23a. Part 1. Enter the disease of con shock, or heart failure. List only	pplications that cause	d the death. De	o not ent	er the mode of dyir	ng, such as cardi				Approximate Interval Between
	Physician		Immediate Cause (Final	And cause on oach	hvon	10	abit.	ructiv	C LVY	g Disc	ese	Onset and Death
)	/Medical		disease or condition resulting in death)	aDue to (or a:	s a consequenc		00)() //-		
М	Examiner				lostr	idi	Im De	II. al	cal	itue		
		Jer	Sequentially list conditions, if any, feading to immediate	Due to (or as	s a consequenc			- 11 1 - 1		1 (- 1)		
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o o	exec en en rial-tr	EX	resulting in death) Last	Due to (or as	s a consequenc	e of):					17/	
8760	cate be executed physicien end the burial-transit	dicai		d								
		led							100	-		
Box	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2 Fetaf dea	*b 2 [Ectopic pregnance			23d. Dat	e of delive	ry
m	deat e attr	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a	at time of death		Other (specify)	/ 		Mo	nth	Day Year
Ö	t the by th lache	hys	9 Unknown	9□ Unknown								
· .	The law requires that the death certifice has been signed by the attending loage 2 should be detached for use as	by P	Part II. Other significant conditions	1	but not resulting		1	ren in Part I.	23e. Did to	obacco use conti	ribute to th	e cause of death?
Ë	quire on sig	Pe	Atila	elesis	01	<u></u>	ind		1 🗆 Y	'es 2 ☐ No	3 Prob	ably 4 Unknown
ပ္တ	s bec	olet			. 3		0		24a. Was	an 24b. \	Were autor	osy findings available inpletion of cause of
Vital Records,	The lav	Completed								rmed?	death?	
		0	25. Was case referred to medical			-		26 Place of De	1 ☐ Yes eath (Check only o	*	☐Yes	2 No
		0 8	examiner? 1 Yes 2 No	Hospital: 1 / Inpat	ient 2□ER/0	Outnation	t 3 DOA Oth	oc.	Home 5 ☐ Resid		or (Coasin	4
ö	Phys er this eral di	-	27. Manner of Death	28a. Date of Inj	urv 28b	. Time of	28c. Injur			now injury occurr		,
<u> </u>	th. After		1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Di	ay Year)	Injury		rk? Yes 2.∐No				
Division	Atternation of the by the	E C	3 Suicide 6 Could not to determined	289. Place of in	jury - At home,	farm, str	eet, factory, office		28f. Location (S	Street and Numb	er or Rura	Route Number,
ā	aior safte safte ii Dir	Certification:	4 Homicide	building, e	tc."(Specify)				City or Tow	m, State)		
	ospit hour unere y fille		29a. Certifier 1 Certifying P	hysician: To the bes	t of my knowled	ge, death	occurred at the tir	ne, date and pfac	e, and due to the	cause(s) and ma	nner as st	ated.
	To the Hospital or Attending Phymiles 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Medical	(Check only 2 Medical Exa	miner: On the basis and manner s	of examination a	and/or inv	vestigation, in my o	opinion, death occ	curred at the time, o	date and place, a	and due to	the cause(s)
	To t To the	Σ	29b. Signature and title of certifier	•			29c. Licens		/	29d. Date signed	1 .	Day, Year)
U	JP.) fame	Wulled			90	6039	6	05/1	010	6
0	120		30. Name and address of person who	completed cause of	death (Item 23a) (Type,	Print) 112	6 000	1. 4	_		
	7		FARID	MURS	SHED			Horex	stown	M	21"	740
	Sta		31. Date filed (Month, Day, Year)		trar's Signature	- And	end	1100		1		
	Registr	ar	MAY 1 1 2	006 Diese	w D.	Sp	Experience					

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		cate of Death		200	5 4605
Physici Medical Exam		Decedent's Name (First, Middle,La	•		Date of Death Month	Day Year	3 Time of Death 1307 hrs
viedicai Exam	iller	Deborah Ann Hil 4a. Facility Name (if not institution, gi		4b. City, Town, or Location of Deatl	April 30, 20	4c. County of Death	
		St. Marys Hospital	ve street and number)	Leonardtown	'	St. Mary's	
Funeral		5 Social Security Number 6. S	ex 7. Age (In yrs last bi	rthday) If Under 1 Year If Under 24Hrs	s. 8. Date of Birth	(MM/DD/YYYY) 9. Bir	thplace (State or
Director		220-31-4136	M 2×F 43	Months Days Hours Mir	Aug. 28	Foreign R 1962 Co	gn untry) MD
		Usual Residence of Decedent			1149. 20	, 1502	· F1D
any		10a. State 10b. County	10c. City, Tow	n or Location	-		10d Inside City Limits
Maryland 28a-f show d at once,	5	MD Wicomic	o Salis	sbury			1 Yes 2 No
Maryl 28a-f d at o	Director	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Cou	ntry?
ith the Maryland 23a or 28a-f sho notified at once.		31453 Old Ocean	City Road	21804		USA	
th wit	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 		14. Race - Amer White, etc.	can Indian, 8lack,
5-0036 led within 72 hours after death with the Maryland Hygiene other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Fur	/	1 Yes 2 X No	1 Yes 2 No specify:		0# B1	ack
ırs aftı ural"	b	15. Decedent's Education (Specify of	or Dates:	Decedent's Usual Occupation (Give kind of	work done	Specify. B1 16b. Kind of Business/	
2 hou	etec	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working life. DO NOT use ret			,
21215-0036 uld be filed within 72 Mental Hygiene marked other than '	ompleted	12th		Laborer		Sheraton	
5-0 filed w Hygie I othe	၂ပ၂	17. Father's Name (First, Middle, Las	()	18.Mother's Name	e (First, Middle, Ma	aiden Surname)	
2121. vuld be fill Mental F marked	a				a Smith		
= 2 g s =	입	19a Informant's Name/Relationship (Mrs. Charmaine Pr	- 1	9b. Mailing Address (Street and Number or 6700 Cornelius Stree			
ore, MC ss 1 and 2 sb of Health an If item 271 her trauma		20a Method of Disposition	20b. Place	of Disposition (Name of cemetery, atory or other place)	Date	20c. Location - City or	Town, State
Baltimore, permit Pages I ar Department of Hes Important: If ite		1 X Burial 2 Cremation 3 4 Departion 5 Other Specific	Spring	ghill Memory Gardens May	6,2006	Hebron, MD	
Baltimo permit Page Department o Important: injury or oth	-	i al re of Funeral Service Live		22. Name and Address of Facility	13 Jerse	y Road Sal	ishury MD
m 99 m	175.16	Srella D	· xorles	Jolley Memorial (Chapel	21	801
Physician /Medical		23a. Part I Enter the disease, o comfailure. List only one cause on e		not enter the mode of dying, such as cardiac of	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)		ovascular disease			Death
			Due to (or as a consequence of):				
	Je	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):				
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of):				
ecuted and transit		events resulting in death) Last					
760, icate be exe physician at the burial -	Physician/Medical	X UNPENDED	AMENDED item#23a,27	,perME,g855,5/24/06 TT			
760, ficate be g physic	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnance			23d. Date of delivery	
certif	cian	past 12 months?	1 Live birth 4 Pregnant at time of death	Fetal death 3 Ectopic pregn.Other (Specify)	ancy	Month [Day Year
Box 68" re death certiff the attending	ıysi	1 Yes 2 No 9 V Unknow		J Citier (Specify)			
that the d		Part II. Other significant conditions	contributing to death but not resulti	ng in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ires that the signed by	d by				1 Yes	2 No 3 Prob	ably 4 V Unknown
ords, w requires s been should	Completed				24a. Was ar autopsy		topsy findings available completion of cause of
eco he law ate has	Щ			.	perform 1 ✓ Yes 2	ned? death?	
ial Re(ian: The certificate	Be C	25. Was case referred to medical		26.Place of Death (Check			
Vital hysician: this certifi	o.	examiner? 1 ✓ Yes 2 No	Hospital: 1	Outpatient 3 DOA Other Nursi	ng Home 5 R	tesidence 6 Other	
ion of tending Pheath. for: After the funeral	ı.	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day, Year) 28b	. Time of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred	
tend death.	atio	2 Accident Pending	tion	1 Yes 2 No			
Division of Vital Records, ral or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could no determin	t be	farm, street, factory, office building, etc.	28f. Location (Str or Town, Sta		ral Route Number, City
Divi		4 Homicide	(Opechy)				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only	er: On the basis of examination and/or	eath occurred at the time, date and place, and investigation, in my opinion, death occurred :			
To with	Med	29b. Signature and title of certifier	and manner stated.	29c. License number		29d. Date signed (Moi	
		anni	,	O.C.M.E.		May 1, 2006	
		30. Name and address of person who	completed cause of death (Item 23a)				
	C //	· ·		Penn Street, Baltimore, MD 2120	1		
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Sandy			
Regis	trar	MAY 2 2 2	006 Jager At				

			1 - For State Registrar	State o	f Maryla		artment of rtificate of			al Hygien	0000	16051	
			1. Decedent's Name (First, Middle, L	ast)						ite of Death	- C. S. U.	3. Time of Death	
	Physici /Medio		Bertha Ellen Har	ndwerk						S 15	ay Year	0835M	
1	Examir		4a. Fecility Name (If not institution, gi		,		4b. City, Town,	-		40	c. County of Death		
			SacrED He	352 FA	OSPIT	AL		BER	CAND		ALLE6	PINA	
	Funeral		5. Social Security Number 6.	Sex 1□M 2ĀF		s. last birthday)	If Under 1 Year Months Days			te of Birth onth, Day, Year	9. Birthp	lace (State or Foreign	
	Director		218-60-1527		59	Yrs.			Oct			yland	
	land		Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or Lo	cation				10d. Inside City Limits		
	f sh	ō					_					1 Yes 2 □ No	
	the roun	Director	MD Garre 10e. Street and Number	EE			10f. Zip Code	antsv.	ırre	100 C	itizen of What Cour	ate /2	
	3a or	ä	34 Railroad Stre	no.t				536		109.0		itiy:	
	me 2	Funerai	11. Marital Status	12. Was Dece	edent Ever in I	U.S. 13.			igin? (Specify Y	es or No-	USA 14. Race - Americ	an Indian.	
ထ	or ite	Ē	1 Never Married 2 Married	Armed Fo	2 € No		Was Decedent of f Yes, specify Cub		n, Puerto Rican,	etc.)	Black, White,		
ලි	al', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	/ 0		1 □ Yes 2 火 □ No	Specify:	:		Specify: Wh	ite	
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Iteme 23a or 28a-f show fra Medical Examirar must be notified at	Completed	15. Decedent's E (Specify only highest g.			16a. Dece	dent's Usual Occu kind of work done	pation	t of worlden	16b. H	Cind of Business/Inc	dustry	
7	thin .	ם	Elementary/Secondary (0-12)	College (1	I-4or 5+)	life.	DO NOT use retire	id)	st of working	i			
7	ed wi	ပ္ပ	llth				Home	maker			Own H	ome	
פ	d oth	Be	17. Father's Name (First, Middle, Las	it)					er's Name (First,		n Sumame)		
<u>×</u>	Men Arke	은	Harry Wilt					Sa	arah Wil	Lt			
Maryland	2 sh and is m		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Stree	and Numbe	er or Rural Route	e Number, City	or Town, State, Zip	Code)	
<u>~</u>	and lealth m 27		Harry B. Handwei	ck, Husb				Street			MD 2153		
9	ges 1 t of H ff ite or ot		20a. Method of Disposition 1 Durial 2 Cremation 3	Removal from	State Con-	Place of Dispo cemetery, crer	sition (Name of natory or other pla	ce)	Date 17 20	20c. L	ocation - City or To Itsville,	wn, State	
<u>E</u>	men tant: jury		4 Donation 5 ☐ Other (Spec	ity)	GE								
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hygiens. Important: If lear 27 is marked other than "natural", or iteme 23a or 28a-f show eny injury or other treumatic event, its Medical Examinat must be notified at once.		21. Signature of Funeral Service Lice	Rema	ae_						l Homes, tsville,		
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that c	aused the dea							Approximate	
	Physician		Immediate Cause (Final disease or condition	, 4 5446 511 5		1v1+5-	system	OVAC	m for	line		Interval Between Onset and Death	
	/Medical		resulting in death)	Due to (or as a conse	quence of):	1	7	1000	(, ,	-		
	Examiner		Sequentially list conditions,	b	1	eart 7	failure						
	ש ש	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):	11		1	1	11		
	icate be executed physicien and s the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	In	rom bo	sed tr	rcus	ord va	Ive pro	Stresis		
, 20	De ex	<u> </u>	rooming in doubly cast	Due to (or as a conse	quence of):							
58760,	sate t	dical	•	d									
S X	ertific sing p		IF FEMALE:										
Box	law requires that the deeth certifit es been signed by the attending p 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		irth 2 Fet	el death 3	Ectopic pregnanc	y			23d. Date of delive Month	,	
0.	the a	sic	1 ☐ Yes 2 ◯XNo 9 ☐ Unknown	4∐Pregn 9☐Unkno	ant at time of o	death 5	Other (specify) _				MORE	Day Year	
ď.	hat the dd by detac		Part II. Other significant conditions	contributing to do	oth but not co	aultia- is the				Did.			
of Vital Records,	w requires that the de been signed by the should be detached	þ	Tarris, evilor eiginiteant conditions	contributing to de	atii but not ie:	suiting in the ur	idenying cause giv	en in Paπ i.	. 23		use contribute to the		
Ö	requ hould	Completed	· · · · · · · · · · · · · · · · · · ·						_ _	1 ☐ Yes 2	□ No 3 □ Proba	ibly 4 Qunknown	
ခ	law 198 to 198 to	ē							24	a. Was an autopsy	24b. Were autop	sy findings available	
=	The lav	ဦ ပြ							10	performed?]Yes 2⊠No	death?		
<u> </u>	ician: Tr certificete rector, pag	Be	25. Was case referred to medical examiner?						of Death (Chec	k only one	1		
5	hys display	ျှ	1 ☐ Yes 2 No			ER/Outpatient		4 🗆 190	rsing Home 5	Residence	6 ☐Other (Specify,)	
_	ding P	<u></u>	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date o	of Injury h, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. De	scribe how injur	y occurred		
<u>s</u>	Attending Physician: r death. ector: After this certifice by the funeral director;	cat	2 Accident investigation 3 Suicide 6 Could not to	ne				Yes 2 ☐ f					
DIVISION	al or A	Certification:	4 Homicide determined	28e. Place	of Injury - At h ng, etc. <i>(Speci</i>	iome, farm, stre	eet, factory, office		28f. Loc City	cation (Street and y or Town, State	nd Number or Rural)	Route Number,	
	To the Hospital or Attendin within 24 hours effer death. To the Funerel Director: Att cumpletely filled in by the fun	Medicai	29a. Certifier (Chack unity one) 1 Certifying Pl	hysician: To the miner: On the ba and mann	isis of examina	owledge, death ation and/or inv	occurred at the tire estigation, in my c	ne, date and pinion, deat	d place, and due th occurred at th	e to the cause(s) e time, date and	and manner as sta place, and due to	ited. the cause(s)	
	o things	Me	29b. Signature and title of certifier		1	127	29c. Licens	e number		29d. Dat	te signed (Month, D	av, Year)	
'	->-0			<	AIDA		Do	56	300	1		*	
			30. Name and address of person who	completed cause	of death (line	m 23a) /Tunc 1	D OC	1 2 6		1/1/4	-y 15, c	2006	
	-3		or 6. e				rint)	10-6	- 1	1119	y 15, a	250-	
	Stat	e	31. Date filed (Month, Day, Year)		gistrar's Signa			- 3	WITE OX.	07.00	1000000	q vivi	
	Registra	_	MAY 1 6	2006	20-0	100	68 0						

Please T

Please Type or Print in Black Indelible Ink. Assure		
State of Maryland / Department of Health and	Mental Hygiene	
Certificate of Death	Reg. No.2006	60
1. Decedent's Name (First, Middle, Last)	Date of Death Month Day Year	3. Time of De
Coorge Levis Hare	April 26, 2006	9:35

Physician
/Medical
Examiner

1	/Medi	cal		Lewis_						45 Oits Tax		ADE TT		000	9.33 FM
	Exami	ner	4a. Fecility Name (ŕ			4b. City, Town, or Location of Death Grantsville				4c. County of Death Garrett		
_				l Mennoni				If Lindo	. 1 Voor						
	Funeral Director		5. Social Security I		Sex 1 M 2 ☐ F	7. Age (In yrs. le	est birthday). Yrs.	Months		Hours	Min.	B. Date of Birt (Month, Da	n y, Year) 7, 1939	9. Birthol Count Mary	lace (State or Foreign try) rland
	p ,		Usual Residence of	T		40- 05-									
	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or items 23a or 28a-1 show ant, the Medical Examiner must be notified at	ō	10a. State	10b. County	rett	10c. City	, Town or Lo	G r ar	ter	1110				10	0d. Inside City Limits 1 Yes 2□No
	the 28a	Director	10e. Street end Nu					10f. Zip		TITE			10a Citizen of	What Count	tn/?
	3a or			dowview I	rive, A	ot. 4-C		101. 210	Joue	215	536		Og. Citizen of What Country? USA		
	death	Funeral	11. Marital Status		12. Was Dec	edent Ever in U.S	S. 13. V	Vas Dece	dent of I			ify Yes or No- can, etc.)	14. Rac	an Indian,	
0	after or ite		1 Never Mari	ried 2 Married	Armed F	2 🖫 No					, Puerto Ri	can, etc.)		ck, White, e	etc.
Maryland 21215-0020	rel',	l by	3 X Widowed	4 Divorced	If Yes, Gi Year or D			☐ Yes	ZX NO	Specify:			Specif	λ: <u>Μ</u>	hite
<u>.</u>	netu	Completed	(Spe	15. Decedent's E cify only highest gr	ducation ade completed)		16a. Deced (Give	ent's Usua kind of wo	al Occup rk done	pation during most d)	t of working		16b. Kind of B	usiness/Ind	lustry
12	within ne.	ш	Elementary/Seco	ondary (0-12)	College (1-4or 5+)	life. L	OO NOT u	se retire	d)					
9 9	Hygie Ther I		17. Father's Name	(First Middle Las	t)			Lo	xgge:		r's Name /	First Middle	Sel: Maiden Surnan	f-emp	loyed
a	d be antal	9 Be	Earl Ha		•/									,,,,	
<u> </u>	mark mark	ို		ame/Relationship	(Type Print)		19h Mailin	a Address	(Street			azenba) Boute Numbe	r, City or Town,	State Zin	Code
Ĕ	Ither 27 is	Ì		Hare, So											e, MD 2153
ē,	s 1 ar f Hea ftem other		20a. Method of Dis			20b. Pla	ace of Dispos	sition (Nar.	ne of			Date	20c. Location		
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health end Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinat must be notified at once.	1		☐ Cremation 3 ☐ 5 ☐ Other (Special							ril 2	8,2006	Bitt	inger	, MD
Ball	permit. Depart Import any Inj once.		21. Signature of Fi	uneral Service Lice	nsee		22.	. Name an	d Addre	ss of Facility	^y Newma	an Fune	eral Ho	mes, I	P.A.
	<u> </u>		- XX	ser UK	uma	el	179	9 Mil	ler	St, F	PO Box	k 275,	Grants	ville	, MD 21536
			23a. Part1. Ent r t shock, or	the disease, or con failure. List only	plications that of	caused the death.	. Do not ente	r the mod	e of dyi	ng, such as o	cardiac or r	respiratory ar	rest,		Approximate Interval Between
9	Physician		Lancador Como	(Fig.)	11	+ +	+				. /	•			Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Metastatic Disease of Lives Due to (or es a consequence of):											2 years.	
		<u>ا</u>	, seeming in account			Due to (or)			1	/
	uted I Insit	퉅	Sequentially list conditions, Due to (or as a consequence of):												
~	execu n and ial-tra	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury										1		
<u> </u>	e be sicia e bur	g	that initiated event	S	ė.	Due to (or	as a consequ	ieuce of).				William			
Box 68760,	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):													
ŏ	th cer tendir rr use	ar/			d										
. E	e dea he att	Sici	Part II. Other signi	ficant conditions	contributing to d	eath but not resul	lting in the un	derlying c	ause giv	en in Part I.		23b. Did to	obacco use ço	ntribute to	the ceuse of death?
P. O.	at the	된	E Quelle mellitus								es 2 No	3 ☐ Proba	ably 4 ☐ Unknown		
Š,	res th signer	ρ	0,				. 1			4					
Division of Vital Records,	requi	Completed	Ha	stroes	ophay,	eal Rey	flux	21	300	RUZI	R	24a. Was a perfor	in autopsy med?	avai	re autopsy findings ilable prior to
ည္ န	law nesb e2s	햩			0 - 4									of de	pletion of cause eath?
ᇹ	: The cate ; pag											1 □ Y	es 212 No	1 🗆	Yes 2□ No
=======================================	Iclen Sertifi Sector	Be	25. Was cese referexaminer?		Hospital:				Oth		of Death (6	Check only or	ne)		
5	Phys this of al dir	ဥ	1 ☐ Yes 2 ☑ 27. Manner of Deat		10	Inpatient 2 E			PA	4 LM Nur			ence 6 □Oth		
5	Attending Physicien: The law requires the redath. ector: Aath. ector, page 2 should be c	Certification:	1 ⊠Natural	5 Pending investigation		of Injury th, Day Year)	28b. Time of Injury	M	8c. Injur Wor 1 □	ya∖ k? Yes 2∐N		a. Describe n	ow injury occurr	ea	
<u>s</u>	uttend deat ctor: ctor: y the	fica	2 ☐ Accident 3 ☐ Suicide	6 Could not be	e as su	of Injury - At hon	ne. farm. stre					. Location (S	treet and Numb	er or Rural	Route Number
3	or ter	er er	4 Homicide	determined		ng, etc. (Specify)		**, ******,	,			City or Town			
	To the Hospital or Attending Physicien: The law within 24 burus effer death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2		29a. Certifier (Check only	1 CertifyIng Pl 2 Medical Exa	nysiclen: To the	best of my know	ledge, death	occurred a	at the tir	ne, date and	l place, and	due to the c	ause(s) and ma	nner as sta	ited.
	the H	ledical	one)		and man	ner stated.	on and/or invi				occurred				
	7 ₹ 0 0	Σ	29b. Signature and	title of certifier				290	. Licens	e number	2 0	2/ /	9d. Date signed	(Month, D	lay, Year)
			> >	() No	my	ny			X.	406	25	5 (your	2/	2004
			30. Name and addr		11	se of death (Item :			43	T 0.	11/	MAR	Mar. C	Jon 1	21525
			31. Date filed (Mon		1470G 0	Registrar's Signatu		odw	ay	4/12	ONN	2009	ings	and a	41470
	Sta Registr		ST. Date lieu (MOI)	MAY - 1	2006	San -	A A	1 .							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 1:20 A M 2006 Kenneth Hanline May 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Garrett County Memorial Hospital 0akland Garrett If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1**⊠**M 2□F 26, 1938 West Virginia 67 Director 235-58-7721 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ir than "naturel", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director 0akland Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 156 Smith Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours atter Department of Health and Mental Hylgiene. Important: If Item 27 is marked other than "naturelf, or Ite eny inlury or other traumatic event, the Naturell Eastern 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Specify. 2 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Worker Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Auvi1 ٩ Α. Hanline Ada 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Terry Hanline, Son 320 Red Oak Circle, Oakland, MD 21550 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Davis Cemetery 05/09/2006 Davis, WV 22. Name and Address of Facility Burdock-Durst Funeral Home 21. Signature of Funeral Service Licensee 21 N. Second St., Oakland, MD 21550 Katherine Sweiter 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition immediate **Physician** arteriosclerotic cardiovascular disease resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physician end detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an completely filled in by the funeral director, page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 25 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 fnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 Yes 2 No 2 ER/Outpatient After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death 2 Accident investigation after death Director; 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D15333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 311 N. 4th Street, Oakland, MD 21550 Dr. Thomas G. Johnson 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 MAY Registrar

			For State State Registrar	e of Maryland / I		rtment of He tificate of D			ene g. No.20	06	16057
	Physici	an	1. Decedent's Name (First, Middle, Last) Agnes Lucille HOLLIDAY					2. Date of Death Month May 5,	Day	Year	3. Time of Death 7:25 a. M
	/Medic Examin		4a. Facility Name (If not institution, give street and Avalon Manor Nursing			4b. City, Town, or L			4c. County	of Death hingt	
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ☑ 6. Sex	7. Age (In yrs. last bi	irthday) Yrs.	Hagers If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 7, 19		9. Birthol	lace (State or Foreign try) y Land
	aryland ehow	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov						10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
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	h with	I D	11829 Robinwood Dr.			21742	2		USA		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Important: If item 27 is marked other than "naturel', or Itema 23a or 28e-f ehow any injury or other traumette event, the Madical Examinar must be notified at ance.	by Funeral	1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Decedent Ever in U.S. ed Forces? ∕es 2 ⊠No s, Give or Dates:	-	/as Decedent of Hisp Yes, specify Cuban, ☐ Yes 2 ☑ No	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - Americ ck, White, e c: wh	
21215-0036	within 72 ho ane. than "natur ne Modical	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) O	ted) ge (1-4or 5+)	(Give I	ent's Usual Occupati kind of work done du O NOT use retired) maker	ion ring most of worki	ng	her own home		
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	To the within To the comple	Me	29b. Signature and title of certifier	\supset		29c. License	number	296	d. Date signed	(Month, E	Day, Year)
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	ath with	ral Dir	6829 Walnut Creel			f. Zip Code 21029		A	g. Citizen of What Co Afghanista	•
9036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show he Madical Examiner must be notified at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes,		anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: As 1	rican Indian, e, etc.
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Division	in the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	building, etc						City or Town, St	ite)	ıral Route Number.
	the Hospital in 24 hours a the Funeral ipletely filled	edical	(Check only 2 Medical Exer	nysicien: To the best of miner: On the basis of and manner sta	examination and/o	eath occurre r investigation	d at the tim on, in my op	e, date and pla inion, death o	ace, and d ccurred at	tue to the cause the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Khon	vole	2	9c. License				ate signed (Monti	
2	(10)		30. Name and address of person who					58965 Sto. 10)O P-		y 2, 2000	0852
	Sta Registi		Saima U. Khawaj 31. Date filed (Month, Day, Year) MAY 0 8 200	Registra	r's Signature		гтке	ore. I	JU KO	CKVIIIE	, rid. Z	JOJZ

06-02912 Brian C. Hurd Please Type or Print in Black Indelible Ink

an C. Hurd	1- For State Certificate of Death									
Physicia edical Exami	an/	legistrar 1. Decedent's Name (First, Middle,Last) Brian C. Hurd		2. Date of Death Month Da April 30, 200	y Year	3. Time of Death 1226 hrs				
<i>)</i>		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death					
Funeral Director		3111 Forestville Road 5. Social Security Number 579 02 6817 6. Sex 7. Age (In yrs. last birthday) 1 4 4 2 F 33	Months Days Hours Min.		Prince George's M/DD/YYYY) 9. Birth Foreign Cour	place (State or				
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene and the first part is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arundel 10c. City, Town or Local G. 10c. Street and Number 110 Warwick Shire Lane, #K, 11. Mantal Status 1 X Never Married 2 Married 3 Widowed 4 Divorced of Yes, Give Year or Dates 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last) Donald W. Hurd	ation len Burnie 10f. Zip Code 21061 Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto Yes 2 X XNo specify: ent's Usual Occupation (Give kind of v most of working life. DO NOT use retire	vork done red) 10g. U Citizen of What Count Inited Stat 14. Race - Americ White, etc. Specify: Whi bb. Kind of Business/In Moving den Surname)	10d. Inside City Limits 1 Yes 2 X No ry? eS an Indian, Black, te dustry					
1D 2' 2 should 1 and M 27 is ms	7	1 (0:-1.	Marwick Shire La							
Baltimore, Normania. Pages I and 2 Department of Health Important: If item 3 injury or other traus		20a. Method of Disposition 1 Burial 2 XX Cremation 3 Removal from State 4 Donation 5 Other Specific Lee Crem	Oc. Location - City or T	own, State						
Baltimo permit. Page Department o Important:		21. Signature of Funeral Service (censee 22.	home, Inc on, MD 207							
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease a. Complications of chronical contents		or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death				
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ic distrib							
۲	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
), be executed sician and urial - transit	edical E	d. X UNPENDED AMENDED item#23a,27,per	rME,g856,6/20/06 TT							
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be exy 4thours after death. Funeral Director: After this certificate has been signed by the attending physician rely filled in by the funeral director, page 2 should be detached for use as the burial-	sician/M	23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 2 2 2 2 2 3 3 3 3 3	Fetal death 3 Ectopic pregna	ancy	23d. Date of delivery Month Da	ay Year				
, P.O. E	by Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	I	cco use contribute to to	,				
of Vital Records, I ge Physician: The law requires the this certificate has been signeral director, page 2 should be metal director, page 2 should be	Completed			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of				
tal Rection: The certificate ector, page	Be Co	25. Was case referred to medical	26.Place of Death (Check							
Vita hysici this call direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie			sidence 6 🗸 Other:	Scene				
ion of ttending P leath. tor: After	ertification:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Death (Month, Day, Year)	1 Yes 2 No	28d. Describe hov						
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Certific	3 Suicide 6 Could not be determined (Specify)	reet, factory, office building, etc.	28f. Location (Stre or Town, State		al Route Number, City				
DIN To the Hospital o within 24 hours af To the Funeral D completely filled i	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ only one) 2 Medical Examiner:On the basis of examination and/or investigated and manner stated.								
± ≥ € 8	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.		9d. Date signed <i>(Mon</i> May 5, 2006	th, Day,Year)				
		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Pe	enn Street, Baltimore, MD 21	1201						
	tato	31. Date filed (Month, Day, Year) Registrar's Signature								

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			For Stata Registrar	State of Mai	ryland / Dep <i>Ce</i>	artmen	t of H	lealth a	and M	lental Hy	/giene	106	16061
	Physic /Medi		1. Decedent's Name (First, Middle, Last Donald Wilbur Jon							2. Date of D Month		200 G	3. Time of Death
	Exami		4a. Facility Name (If not institution, give Washington County	Hospital		Hage	erst			J	Was	nty of Death hingt	on
ļ,	Funeral Director		5. Social Security Number 6. S 213-16-1361 1 Usual Residence of Decedent	ex 7. Age 7. Age 83	(In yrs. last birthday, Yrs.	Months	1 Year Days	If Under Hours	Min,	8. Date of Bi (Month, D 05/21)	1922	9. Birth Cos	nptace (State or Foreig untry) MD
	e Maryland ta-f show	ctor	10a. State 10b. County MD Washing		10c. City, Town or L Hagerstor								10d. Inside City Limits
	th with th	ai Dire	10e. Street and Number 17821 Woodcrest R	oad		10f. Zip	Code 740				10g. Citizen US	of What Cou	untry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examinar must be notified at ances.	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Deced If Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)		Race - Amer Black, White cify:	
C	filed within 72 h Hygiene. other than "natuent, ine Medica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0·12)	lucation de completed) Cotlege (1-4or 5+)	(Give	dent's Usua kind of wo DO NOT us gineel	k done d e retired	turina most	t of worki	ing	16b. Kind of	Business/li	•
	should be fill ind Mental H is marked oth umatic sven	To Be	17. Father's Name (First, Middle, Last) Wilbur Carl Jones					He	len .	Annamay		,	
	1 and 2 sho Health and Iem 27 is mother traum		19a. Informant's Name/Relationship (7 Donna L. Moats /		9501	l Ment	zer	Gap 1	Road	, Wayne	esboro,	PA 1	p Code) 7268
	pernit. Pages 1 Department of H Important: If ite any njury or ott		20a. Method of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Other (Specify 21. Signature of Forerat Service Licen)	20b. Place of Dispo cometery, cres Cedar Lav		1. G	ln. 0	5/12		Hager Minni	stown	
e e			23a. Part1. Enter the disease, or compshock, or heart failure. List only	plications that caused th	5	305 N	Pot	tomac	Str	eet, Ha	agersto		D 21740
	death certificate be executed Physician and e attending physician and of for use as the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the cond	consequence of):	ruction art	Fai	Pal m	iona	M c	disea.	2-€	Interval Between Onset and Death
.O. Box 6	death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 □ Live birth 2 [4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pro						Date of deliver	ery Day Year
S,	quires that n signed b uld be deta	þ	Part II. Other significant conditions co	ontributing to death but r	not resulting in the u	nderlying ca	use give	n in Part I.			obacco use co Yes 2 \(\subseteq \text{No} \)		he cause of death?
	ien: The law requires that the rtificate has been signed by th stor, page 2 should be detache	Completed					-			24a. Was autor perfo		. Were auto prior to co death? 1 \(\text{Yes}	psy findings available mptetion of cause of 2 \(\text{No} \)
ō	ng Physic Iter this ce neral direc	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Actident Investigation	Hospital: 1 Anpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatier 28b. Time of Injury		c. Injury Work	r: 4 🗆 Nur	sing Hon		dence 6 0		y)
ā	P S S S S	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of Injury building, etc. (- At home, farm, str Specify)	eet, factory	office		2	8f. Location (S City or Tox	Street and Num vn. State)	nber or Rura	il Route Number,
:	Hospin 4 hour Funer tely fill	edical	29a. Certifier 1 GCertifying Phy (Check only one) 2 Medical Exam	rsician: To the best of n iner: On the basis of ex and manner stated	amination and/or in:	occurred a vestigation,	t the time in my op	e, date and inion, death	place, a	nd due to the	cause(s) and n date and place	nanner as si , and due to	lated. the cause(s)
Ç-		M	29b. Signature and title of certifier	Section 1	h //km 22.5 7		License () S	number 2 3	23		29d. Date sign		Day, Year)
0	Z Sta Registr		30. Name and address of person who c Dasle 31. Date filed (Month, Day, Year) MAY 1 0 20	1126 32. Registrar's	Opal (Du Ou	t		try	·Mot	217	40	

ORIGINAL

	·	1 - For State Registrar	State o	f Marylan		artmen rtificate			ind Me	_	giene Reg. No.	2006	5	6062
Physici		Decedent's Name (First, Middle Elmer W. Jones								2. Date of De Month	Day 2006	Yea		Time of Death
/Medio		4a. Facility Name (If not institution	, give street and nu	nber)				Location of		nay +,	4c. (County of D		-0.40-
		2603 Terrapin	Rd 6. Sex	7. Age (In yrs.	last hirthday			oring If Under 2	24 Hrs.	9 Date of Bird		ntgom		(State or Foreign
Funeral Director		5. Social Security Number 203–12–6959	1.XM 2□F	7. Age (III yrs. 82	V	Months	Days	Hours	Min.	8. Date of Bin (Month, Da Dec 27	y, Year) 1, 19	23		Sylvania
and and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d.	Inside City Limits
72 hours after death with the Maryland natural, or Items 23e or 28e-1 ehow disal Examiner must be notilited at	tor	Maryland Mon	tgomery	Si	lver S	pring								1 ☐ Yes 2 🛣No
in the	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What	Country?	
23a		2603 Terrapin	Rd			20	0906				USA			
dea	Funeral	11. Marital Status	Armed Fo	edent Ever in U		Was Deced	lent of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	- 1	4. Race - A Black, W		ndian,
or It		1 Never Married 2 Marr	ned 1 TYPYes If Yes, Gir	2 No 194	+2-	1 ☐ Yes		Specify:				Specify:		
hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced	Year of D	ates: 13	16a, Dece	dent's Usua	d Occupa	tion				M of Busine	hite ss/Indust	'rv
	Completed	(Specify only highest Elementary/Secondary (0-12)		1-40r5+)	(Give	kind of wor DO NOT us	rk done d e retired)	uring most	t of workin	ng	100.14	10 01 0031110	341110431	· y
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12 sh h and 7 is n traum		19a. Informant's Name/Relations								Route Numb				de)
1 and Health Hem 27		Violet Jones/V	wile	20b. F	Place of Dispo cemetery, cre					ver Spr		cation - City		State
Pages ment of land ury or o		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		State					Mass	8 2006	р	- ald	11.	MD
ortan International		21. Signature of Funeral Service		Pai	CKTAWN 2	Memo.	d Addres	s of Facility	y Hine	8,2006 es-Rina	ldi.	ockvi Funer		
Depermit Depermit any In		towner	A Len	lan-										MD 20904
		23a. Part1. Enter the disease, or shock or heart failure. List	complications that	ceused the deat									Ap	proximate erval Between
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/Medical Examiner		resulting in death)	Due to	(or as a consec							<u>-</u>			
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w requires that been signed to should be deti	ed by	DIABETES MEL	LITUS							1 🗆	Yes 2]No 3[Probably	y 4 XUnknown
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hysic this co	ို	1 ☐ Yes 2 🗶 No			ER/Outpatie			4 🗆 140		ne 5 ⊠ Resi			Specify)	
ing P	o E	27. Manner of Death 1 XNatural 5 Pendir	194	of Injury oth, Day Year)	28b. Time o Injury	of 12	8c. Injury Work	rat ⊲? Yes 2.∐.I		28d. Describe	how injury	occurred /		
death death ctor: y the	ficat	2 Accident investi 3 Suicide 6 Could	not be	e of Injury - At h	ome, farm, st			163 2 🖂 1		28f. Location (Street and	d Number o	Rural Re	oute Number.
Ital or A	Certification:	4 Homicide determ	build	ling, etc. (Speci	fy)					City or To	wn, State))		
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours effer death. To the Funeral Director: Affer this certificete has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier 1 X Certifyin (Check only one) Medical	ng Physician: To th Examiner: On the l and mar	e best of my kno basis of examina ner stated.	owledge, deat ation and/or in	th occurred nvestigation	at the tim , in my op	ie, date an pinion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) date and	and manner place, and	r as state due to the	d. e cause(s)
To the within To the comp	Me	29b. Signature and title of certifie	ər			290	c. License	number	111		29d. Date	e signed (M	onth, Day	v, Year)
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. 6		30. Name and address of person					,	n •		00010		/ /	/	Ŧ
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 0^{Day} **Physician** 2006 P^{M} Ruth Somerville Jones 6:21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 05/18/1917 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) / Funeral Days Hours 1 M 2 XF 88 155-01-3741 Yrs Rocky Mount, NC Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or iteme 23s or 28s-f show the Medical Exampler must be notified at 1≹Yes 2 No Director Prince George's Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 664 Harry S. Truman Drive 20774 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If item 27 is marked other then "natural", or ite 1 ☐ Yes 2 🔼 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Yes. Give 2 3 Nidowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Unknown College (1-4or 5+) Financial Assistant Private Institute 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Moses Thomas Somerville Mamie Bell Somerville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancie J. McCORMICK -daughter 664 Harry S. Truman Drive; Largo, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite eny injury or ot once. Ivy Hill Cemetery 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05/11/2006 Philadelphia, PA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3831 Georgia Ave., N.W. Latney's Funeral Home Washington, DC 20011 Nichams appl 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final FATAL Physician disease or condition resulting in death) /Medical ue to (or as a consequence of) **Examiner** ANCREATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Dale of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Dav 4 Pregnant at lime of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 2 X No 1 Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this : After this funeral of 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No i Director: / investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who comple ed cause of death (Item 23a) (Type, Print) HOSPITAL DR 3001 KAYMOND 31. Date filed (Month, Day, Year) MAY 08 32. Registrar's Signature State 2006 Registrar

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ath certif	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	⊒Ectopic ⊒ Other (pregnancy specify)				Date of deliv Month	ery Day Year
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Division of Vital Re To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier Certifying Phys	sician: To the best of m ner: On the basis of ex and manner stated	amination and/or i	th occurre	ed at the tim on, in my op	e, date and place inion, death occu	e, and due to the orred at the time,	cause(s) and date and place	manner as s e, and due t	stated. to the cause(s)
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MJL		30. Name and address of person who co	mplet cause of deat	h (Item 23a) (Type	, Print)				1		6 MD 2/157
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e, M l and 2 Health item 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery	y.	Date 2	20c. Location - City or	Town, State
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-		Name and address of person who completed cause of death (Item 23a) Laron Locke MD.	e, MD 2120	1		
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Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Viola **Physician** Kenner 12:10 P M May 14 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Frostburg Frostburg Village Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 17 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 25 F 215-26-6467 92 1913 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a: State raf', or Itema 23a or 28a-f show Examiner must be notified at Westernport MD. Allegany XXYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itema 23a or 2, any jury or other traumatic event, the Medical Examinar manages. 114 A Philos Ave. 21562 United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: Specify: 3 Vidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housework Homemaker unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernard Riggleman Elizabeth Norris P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15119 New Georges Creek Rd, Frostburg Maryland 21532 Richard Kenner/ son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 05/17/ **Burial** 2 ☐ Cremation 3 ☐ Removal from State Cumberland Maryland Rest Lawn Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2006 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee + Wand 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician diomusoal years /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner been signed by the attending physician and should be detached for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 × Probebly 1 ☐ Yes 2 ☐ No 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 Tes :: After this certifica e funeral director, p i or Attending Physician: after death. Director: After this certifica 25. Was case re rirred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 7 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at a Work? 28d. Describe how injury occurred 28b. Time of 27. Manger of C Certification: 5 Pending investigation 1 Natural 1 Tyes 2 TNo completely filled in by the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number o co of ted se of eath (Item 23a) (Type, rint) Dr. Shin Eung Kim, 90 Main St, Westernport, MD. 31. Date filed (Month, Day, Year) 32. Ratistrar's Signature State MAY 16 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** May 2006 11:20 PM Frederick D. Kraeuter, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Berlin Atlantic General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 17, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral Ж**М 2□ F Months Days Hours 1929 Pennsylvania 160 22 6611 Director Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County Worde I the Madical Exertiner must be natified at 1 ☐ Yes 2X No Director Howard Ellicott City MD 288-f 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number ö United States 21042 3625 Valley Road 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 DXYes 2 □ No If Yes, Give Year or Dates: 1950- Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify. þ 1950-55 White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government 12 Mechanical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) mit. Pages 1 and 2 should be file partment of Health and Mental Hypertant: If Item 27 is marked oth y injury or other traumatic eventy. Be Freda Lay Fred Kraeuter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Betty A. Kraeuter/Wife 3625 Valley Road Ellicott City, MD 21042 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Crest Lawn Memorial 5-10-2006 Marriottsville, MD 4 □Donation 5 □Other (Specify) permit.
Departm
Importa
any inju 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 【XNo 2XNo 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 NOA ð 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After or Attending Division 1 Natural 5 Pending 1 TYes 2 No death. investigation 2 Accident after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completely filled in by th 4 Homicide To the Hospital 2sa. Cartillor 🔯 Cartifying Physician: To the best of my knowledge "death occurred at the time," date and place, and dise to the natise(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1044293 May 8, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21228 Catronlle ON. Pollins Kees 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 9 2006 & Garle Registrar

ORIGINAL

06-03050 Charles R. Kline, Jr.

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Certi	ficate of	Death		R	eg. No.	000 1000		
Physici edical Exam		1. Decedent's Name (First, Middle,Last) Charles Robert Kline, Jr. 2. Date of Death Month Day Yea May 5, 2006						3. Time of Death 1726 hrs			
cuicai Exami	IIIGI	4a. Facility Name (if not institution, give street and nur	•	41	o. City, Town, or L	ocation of De	May 5, 20	4c. County of			
		Washington County Hospital	on								
Funeral		000 -1 0010	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hours		` 1.	Birthplace (State or oreign		
Director		220-54-3843 ₁ X _{M 2} F	48	Yrs.	Morning Buye	I TIOUTO	Min. 06/06,	/195/	Country) MD		
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location	n				10d. Inside City Limits		
ind show	5	MD Washington	Hage	rstown					1 X Yes 2 No		
Maryla 28a-f d at or	Director	10e. Street and Number	Ant ON	I	10f. Zip Code 21,740	-	1	0g. Citizen of What	Country?		
ith the Maryland 23a or 28a-f show any notified at once.	ä	156 S. Potomac Street,						US			
eath wi	Funeral	1 Never Married 2 X Married Armed Fo			Decedent of Hisps, specify Cuban,		(Specify Yes or No erto Rican, etc.)	- 14. Race White, o	American Indian, Black, etc.		
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5-0036 Led within 7 Hygiene. I other than	힝	17. Father's Name (First, Middle, Last)	1				ame (First, Middle, M				
21215-0036 Juld be filed within 72 hours after Mental Hygiene, marked other than "natural", is event, the Medical Examiner.	B B	Charles Robert Kline, S	r.				Lee Stri				
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Helland Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traunnatic event, the Medical Examiner must be notified at once.	욘	19a Informant's Name/Relationship (Type, Print) Sharon E. Kline / Wife					or Rural Route Num				
e, N l and 2 Health item 2		20a. Method of Disposition		ce of Disposit	ion (Name of ceme		Date	20c. Location - C			
Baltimore, permit Pages I ar Department of Hea Important: If ite njury or other tr		1 X Burial 2 Cremation 3 Removal fro 4 Donation 5 Other Specify:	III Glate	matory or other ar Lawn	n Mem. Go	$\ln \cdot \mid_{0}$	5/10/2006	 Hagersto	own. MD		
Balti permit Departm Imports injinry o		21. Signature of Funeral Service Vicensee					erald N.	Minnich	Funeral Home		
Physician	٤	23a. Part I Enter the disease, or complications that ca	used the death. D	30	5 N. Pot	omac S	treet. Ha	gerstown	. MD 21740		
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Inju						ser, errestr, or mount	Between Onset and Death		
Examiner			consequence of):								
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Box 687 ne death certific	iciar	4 Pregna	ant at time of death		er (Specify)	_Ectopic pre	gnancy	Month	Day Year		
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ires that the signed by t	þ	Part II. Other significant conditions contributing to	death but not resu	alting in the un	denying cause giv	en in Parti.			Probably 4 V Unknown		
Division of Vital Records, rate downers and a Attending Physician: The law require as after dear After this certificate has been sixed in by the funeral director, page 2 should b	Completed				<u> </u>		24a. Was a		re autopsy findings available		
ital Recorician: The law 1	d W						autop perfor 1 ✔ Yes	med? dea	or to completion of cause of http://www.nth?		
Vital Rec ysician: The his certificate director, page	Be C	25 Was case referred to medical		-	26.Place o	of Death (Che		2 140 1 0	Yes 2 No		
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n of Ading Ph. h. After t		27. Manner of Death 1 Natural 5 Pending 28a. Date of Month: FOUND:	of Injury 28 Day,Year) F	8b. Time of Inj FOUND:		at Work?		now injury occurred auto collision			
ivisior or Attend after death Director:	ficat	2 Accident Investigation May 5, 20	006 1 of Injury - At home	640 hrs e, farm, street			28f. Location (S	treet and Number	or Rural Route Number, City		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Puneral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier (Check only one) 2 Medical Examiner: On the basis o									
To the To the Comp	Medical	29b. Signature and title of certifier		or investigation	29c. License				(Month, Day, Year)		
dh		1/1/2/2			O.C.M			May 6, 2006	,Jili, Day, (Gar)		
13		30. Name and address of person who completed cause	of death (Item 23	Ba)							
19		Theodore King MD. Assistant Medic	March Co.			imore, MD	21201				
S Regis	tate trar	31. Date filed (Months GavyYear) 2006 32. Ref	istrar's Signature	. Spe	Li)						

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State Registra	e s	WAS NINGTON 31. Date filed (Month, Day, Year)	2006 32.	HOSPI Registrar's Signa	TAL ature	HAG	ERST	rown	m	ARYLA	ND	21740	,	

		1	For State Registrar	State of M	larylan		artment of tificate o				iene	06	16070
	Physicia	an	Decedent's Name (First, Middle, Last	ORA	GRACE	KEEI	ER			Date of Deat Month		Year 06	3. Time of Death 7:21 A M
	/Medic Examin		4a. Facility Name (If not institution, give Westminster Nursi			nter	4b. City, Town Westmi		of Death		4c. County Carro		ounty
F	Funeral Director		210-30-0073	x 7. A] M 2∏ F		ast birthday) 99 Yrs.	If Under 1 Yes Months Day		Min. A	Date of Birth (Month, Day, pr. 26	, 1907	Сои	olace (State or Foreign ntry) sylvania
	Aaryland I show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll	County		, Town or Lo							10d. fnside City Limits 1 ☐ Yes 2 X No
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Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licensea 22. Name and Address of Facility Skiles Funer									eral Home Taneytown, Md. 2178	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each	ed the deatl line.	n. Do not en	er the mode of o	tying, such as	s cardiac or r	espiratory arre	est,		Approximate Interval Between Onset and Death
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of	g Physier this	n: To	1 Yes XNo 27. Manner of Death	1 ☐ Inpa 28a. Date of fr (Month, D	jury	28b. Time o	IL 3 DOA	njury at Vork?			ence 6 Oth ow injury occurr		ry)
sior	Attending r death. ector: After by the fune	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				M 1	Yes 2		f Location /Cl	tract and Mumb	or or Cur	al Route Number,
Division	el or At s after d il Direct	Certification;	4 Homicide determined	building,	etc. <i>(Specil</i>	ome, rarm, st y)	reet, factory, offi	ce		City or Town	n, State)	er or nur	ar noble Rumber,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edicai	29a. Certifier Check only one) Check only	ysicien: To the beariner: On the basis and manner	of examina		vestigation, in m	y opinion, de	ath occurred	at the time, d	ate and place,	and due t	o the cause(s)
)	To the within 2 To the complet	M	29b. Signature and title of certifier	ulomo	4	JDNG JSICH		ense number 2115	-		Ped. Date signer	_	
	5		ARTHUR L. PU	completed cause of		n 23a) (Type		N RI) NE	STM M		10	21157
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				State of Maryland / Departs State rtment of Health and M tificate of Death		ene J. No.2 () (06	16071	
		Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death	
		/Medic Examin	al	Clinton Kenneth Lokey 4a. Facility Name (If not institution, give street and number)	May	4c County	of Death	<u></u>	
	1	4	Z .	Manokin Manor	8. Date of Birth	20	mere	lace (State or Foreign	
	7. 26. 4	Funeral Director		5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday) 577-48-3019 88 Yrs.	Months Days Hours Min.	(Month, Day,)		Cour	try)
		and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation			1	0d. Inside City Limits
		Maryli III aho	tor	MD Somerset Princess	Anne				1 Xves 2 □ No
_		death with the Maryland ima 23a or 28a-f ahow r ment be rediffed at	Director	10e. Street and Number	10f. Zip Code	109	g. Citizen ol V		itry?
a		na 23a	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	21853 Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Rac	SA e · Americ	
4:30pm	36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat, or itame 23a or 28a-1 ahow minuty or other traumatic avant. The Medical Examinating invalve invalve in colling an orea.	by Fun	1 Never Married 2 Married 1 Yes 2 No	Yes, specify Cuban, Mexican, Puerto I	Hican, etc.)	Specify	k, White,	
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ري	d 21	Hygier Hygier other ti		12 4 Chief 17. Father's Name (First, Middle, Last)	Historian 18. Mother's Name		lst Ar aiden Sumam		
Ġ.	/lan	Mental Mental arked c	To Be	John Raymond Lokey	Elsie Ge	rtruid P	arsons		
inten Loke,	Man	d 2 sho h and 7 Is mu trauma			Address (Street and Number or Rura				
ā	re, l	s 1 and if Healt item 2 other		20a. Method of Disposition 20b. Place of Dispos	Somerset Avenue, into (Name of alony or other place)		Oc. Location -	•	
	Baltimore, Maryland 2121	Page tment c tant: If jury or		4 Donation 5 Other (Specify) Salishury	Crematory 05/10	/2006 S	alisbu	ry,	ID
J	Ball	Depertiment Depertiment Important in any in		1.0 1.0 1.0 1.0 1.0 1.0 1.0 1.0 1.0 1.0	Name and Address of Facility Home 673 Somerset Ave.		ee Ann	o. Mi	21853
		14	A	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
	As .	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) #\$ CU)					Onsot and Doam
		Examiner	4 0	Due to (or as a consequence of): Wanha					
		ed sit	iner	Sequentially list conditions, If any leading to infractable cause. Enter Underlying Cause (Disease or injury					
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9	9	certific nding p use as	/Mec	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	_		23d. Da	te ol delive	эгу
may 812). B	The law requires that the death certificate be executed ate hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Completed by Physician/Medical	in the pact 12 menths?	Ectopic pregnancy Other (specify)		Мо	nth	Day Year
B	Р.	that th	y Phy	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.	23e. Did toba	acco use cont	ribute to t	ne cause ol death?
_	ords	equires en sign	ted b			1 ☐ Yes	2 □ No	3 Prot	ably 4 Unknown
	3ecc	hes be	mpie			24a. Was an autopsy perform	ed2	prior to co death?	psy findings available mpletion of cause of
	tal	hysician: The law his certificate hes t i director, page 2 s	0	25. Was case referred to medical	26. Place of Death	1 Yes 2	Ø No	1 □ Yes	2□ No
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	ono	ding P th. After t	tion:	27. Manyer of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	28c, Injury at Work? M 1 Yes 2 No	28d. Describe hov	v injury occur	red	
	Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28l. Location (Stre City or Town,	eet and Numb State)	er or Rura	il Route Number,
	D	spital o	al Ce	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death					
		the Horin 24 h the Fur	ledical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invand manner stated.					
4		To To	Σ	29b. Signature and title of certifier	29c. License number		d. Date signe		
				30. Name and address of person who completed cause of death (Item 23a) (Type, I			7.		11 A 2 CDI.
		200.000		31. Date liled (Month, Day, Year) 32. Registrar's Signature		SAZ	1350/	7	019 78 9
		St Regist	ate rar	MAY 1.2 2006	brast !				

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	•	epartment of Health and No Pertificate of Death	Mental Hygie Reg.	-0000 10000				
- E	Physicia		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month May 1,	Day 2006 Year 3. Time of Death 10:01 PM				
	/Medic	al	Theodore A. Li		4b. City, Town, or Location of Death		2006 10:01 PM 4c. County of Death				
	Examin	er	4a. Facility Name (If not institution, give s Anne Arundel Medic		Annapolis		Anne Arundel				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	*	8. Date of Birth	9. Birthplace (State or Foreign				
36	Director		579-38-2017	XM 2□F 82 Yrs	S. Months Days Hours Will.	Oct. 14,	1923 New York				
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location		10d. Inside City Limits				
	Maryl	ţō									
	h the	Director	10e. Street and Number		10f. Zip Code 21401	10g.	Citizen of What Country?				
	23a c	raiD	3022 Friends Road	U. S. A.							
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Itema 23s or 28s-f show important: If Item 27 is marked other than "naturel", or Itema 28s or 28s-f show inportant: If Item 27 is marked other than "naturel", or Item 25 is not 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 25 in 2	by Funerai	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 □ No Navy If Yes, Give Year or Dates: WW 2	 Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 XNo Specify: 	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XNo Specify:					
9	r2 hou	ted	15. Decedent's Edu (Specify only highest grade	cation 16a. D	ecedent's Usual Occupation	kina 161	b. Kind of Business/Industry				
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22	Hed w Hygier ther th		17. Father's Name (First, Middle, Last)	5+ P1	rofessor	ne (First, Middle, Mai	<u> </u>				
and	d be fental liked of	To Be	Nathan Litovitz		Mary	Friefeld					
Maryland	id 2 shoulth and Milth and	-	19a. Informant's Name/Relationship (Ty Charlotte R. Lito		Mailing Address (Street and Number or Ru 22 Friends Road, An						
ē,	s 1 ar		20a. Method of Disposition	remetery	isposition (Name of crematory or other place)	Date 20	c. Location - City or Town, State				
altimore,	Page nent o		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		avid Mem. Gdns 5-4-	2006 Fa.	lls Church, Virginia				
Balt	permit. Departr Importa		21. Signature of Funeral Service Licens	Stottlemuer	22. Name and Address of Facility Edward Sagel Funer 1091 Rockville Pik	e. Rockvi	lle. Maryland 20852				
	Physician		Immediate Cause (Final disease or condition	ications that caused the reath. Do not	Note the mode of dying, such as cardiac Market Accident	or respiratory arrest	Approximate Interval Between Onset and Death				
	/Medical Examiner		resulting in death)	Due to (or as a consequence of)	Attial Cibille	m'rm	days				
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	ficate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с							
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Box 6	death certificate be executed e attending physician and nd for use as the burial-transi	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	a 🗆 🗆		23d. Date of delivery				
	the atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year				
Q.	that the deatled by the atte	Phys	9 Unknown		ha and dahira a sana alima in Carl	220 Did tobar	co use contribute to the cause of death?				
	Se Lg	þ	Part II. Dther significant conditions co		on Hemodrays	1 Yes	2 No 3 Probably 4 Unknown				
Sor	w require been sig should b	etec	metasoni C		Carcinonno	24a. Was an	24b. Were autopsy findings available				
Vital Records,	The ate h page	Completed	1,-018 /1 184 1 0	1100 000 0000	2000(1.0)	autopsy performe	prior to completion of cause of				
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of	this al dii	. To	1 ☐ Yes 2 No 27. Manper of Death	1 Alapatient 2 ☐ ER/Outp 28a. Date of Injury 28b. Tir	atient 3 DOA 4 Nursing F	lome 5 Residence 28d. Describe how	e 6 Other (Specify)				
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Division of	il or Attending after death. I Director: After d in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street and Number or Rural Route Number City or Town, State)					
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	within To th comp	Me	29b. Signature and title of certifier	_	29c. License number		Date signed (Month, Day, Year)				
)	<i>4</i> _	Here Chemans up DO8314 051021200 (30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PEORGE C. SAMANOS MD I lo Defense Highung Annopolism n									
	(0		30. Name and address of person who c	completed cause of death (Item 23a) (T	116 Defense Hi	ghung R	tumopalism n 2 140				
-3	St. Regist	ate	31. Date filed (Month, Day, Year)	37 Registrar's Signature	book						

						00/11/100	ate of	Douin		Reg. No.		101	
	1. Decedent's Nan	ne (First, Middle,	, Last)						2. Date of D	Death Day	Year	3. Time of D	
an cal	George		ine, S						May	8, 20	006	3:40	
ner	4a. Facility Name	(If not institution,	give street	and number)			4	4b. City, Town, or		ath 4c. Co	unty of Death	1	
		Grove N					d 4 M		Spring			gomery	
	5. Social Security		6. Sex 1 □XM 2		In yrs. last bir	Yrs. Month	der 1 Year ns Days	If Under 24 Hr Hours Mir	n. (Month, L	Birth Day, Year)		place (State or intry)	
	578-28-				79	1101			Aug.	9, 1926	Wasi	hington	
	10a. State	10b. County		1	Oc. City, Tow	n or Location						10d. Inside City	
to	Maryland	Monte	gomery		0	lney						1 ☐ Yes 2	
Director	10e. Street and Nu	ımber			-	10f. 2	Zip Code			10g. Citizen	of What Cou	intry?	
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Funeral	11. Marital Status		12. W	as Decedent Evened Forces?	er in U,S.	13. Was Dec	cedent of H	lispanic Origin? (an, Mexican, Pue	Specify Yes or N	No- 14.	Race - Amer Black, White		
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E G	Elementary/Sec	ondary (0-12)	Co	ollege (1-4or 5+)						7.	.+		
	17. Father's Name	(First Middle I	acti			Self-H	Turbroz		ama (Firet Midd		itomot:	rve	
Be									lame (First, Middle, Maiden Surname) ys Haig				
မ	19a. Informant's N		in /Type Pr	rint)	10h	Mailing Addre	ace /Street	and Number or F		un Stato 7	in Code)		
	Ann P.			"",		_		Court, O					
	20a. Method of Dis					Disposition (A ry, crematory o			Date		ion - City or T		
	1. ◯X Burial 2	Cremation				y, crematory o n Memoria			May 1: 2006	1,	-		
	21. Signature of F	5 Other (Sp.			- 0.2.7.2.0.11.2				1			Marylan	
	21. Signature of 1	uneral cervice L	icensee	0				ssofFacility Collins				MD 200	
	23a. Part1. Elter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	23a. Part1. Enter shock, or he	the disease, or o art failure. List o	complication only one cau	is that caused th ise on each line.	e death. Do r	not enter the m	ode of dyin	ng, such as cardia	ac or respiratory	arrest,		Approximate Interval Between	
	Immediate Cause	(F:1										Onset and De	
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	disease or conditi-	on	a. Yr	VELLWON	AIV							3 DAYS	
er	disease or conditi resulting in death)	on	a. Yr			consequence o	of):					3 DAYS	
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	/Medic	al	HENRY 4a. Facility Name (If not institution		LOHMAN umber)	IN	4b.	. City, Town, or	Location	of Death	MAY 2,		County of De	10:5	0 P
	Examin	er	HOLY CROSS HOSPITA					SILVER SF	PRING			МО	NTGOMERY	7	
	Funeral		5. Social Security Number	6. Sex	7. Age (l	n yrs. last birth	hday) If	Under 1 Year onths Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th v. Year)	9. Bi	rthplace (Star	te or Foreign
	Director		045-24-6280	1(ŽM 2□F		74 Y	rs.	July 5 Suy 5	,,,,,,,		JUNE 15,	1931		YORK	
	pur *		Usual Residence of Decedent 10a. State 10b. County		10	Oc. City, Town	or Location	on .						10d. Inside	City Limits
	Aaryla r eho	ច់		EDV	17	ENSINGTO	OM.							1 🖾 Y	'es 2□No
	the A	Director	MARYLAND MONTGOM 10e. Street and Number	EKI	I	ENSTINGTO		Of. Zip Code				10g. Citi	zen of What C	country?	
	3e or	0	11319 WOODSON AVEN	HE.				20895	5			U.S	.A.		
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Q	within 72 hours after death with the Maryland ene. Itan "natural" or Iteme 23e or 28e-f ehow Ite Madical Exeminer must be notified at		1 ☐ Never Married 2 🕅 Marr		2 No			Yes 2⊠ No	Specify:				C'4	HITE	
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0	Hyg other	0	17. Father's Name (First, Middle,	Last)					18. Moth	er's Name	(First, Middle	, Maiden	Sumame)		
land	Ald be Alonta rked tic ev	To B	LEROY HENRY LOHMAN	N					LUCIL	LE MAF	RIE CHAPM	1AN			
Mary	and A		19a. Informant's Name/Relations	hip (Type, Print)		19b.	Mailing Ad	ddress (Street a	and Numb	er or Rura	al Route Numb	er, City o	Town, State,	Zip Code)	
≥ .	and and m 27		FAY LOHMANN/WIFE					ODSON AVE	ENUE,					- T Ot-1-	
o	H ite		20a. Method of Disposition 1 ☐ Burial 2 ☼ Cremation	3 Removal from		20b. Place of cemetery	y, cremato	n (Name or ry or other plac	(8)		Date	20c. Lo	cation - City o	or rown, State	•
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. I without of Heelih and Mental Hygiene. Inportant: if item 27 is marked other than "natural; or items 23a or 28a-1 show enyolity or other traumatic event, the Mudical Examinar must be notified at once.		4 Donation 5 Other (S			FORT LIN		CREMATORY		05/09	/2006	BREN	TWOOD, M	1ARYLAND	
g Q	Depa impo eny i		21. Signature of Funeral Service	Ludos	177 CL			S-RINALDI O NEW HAN			OME, INC.	ER SP	RING, MA	RYLAND	20904
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	cause the	e death. Do n	•							Approxi	
	Physician		Immediate Cause (Final disease or condition	-		C LEAK, S	SEPSTS							Onset a	nd Death
	/Medical		resulting in death)	a		consequence of								 	· · · · · · · · · · · · · · · · · · ·
	Examiner	L	Sequentially list conditions,			TOTAL (OMY							
7	ed sslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2		consequence of		D							
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8/60	cate be executed physicien and the burial-transit	cai		d											_
9	tificati g phy as th	ᇴ													
XOR	th cert endin	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of birth 2	pregnancy Fetal death	3 □Ect	opic pregnancy	,			:	23d. Date of d Month	elivery Day	Year
	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pre 9□ Unk		ne of death		her (specify)				ļ	MOHUI	Oay	i bai
J.	d by t		Part II. Other significant conditi	ons contributing to	death but r	not resulting in	the under	riving cause give	en in Part	1	23e. Did	tobacco u	se contribute	to the cause	of death?
ds,	signe d be d	d by	, un in outside significant					,,g g			10	Yes 2	□No 3□1	Probably 4	∐Unknown
Ö	w require been st	ete									24a. Was	an	24b. Were	autopsy findir	ngs available
Vital Records,	stcien: The law certificate has l irector, page 2 s	Completed									auto	psy ormed?	prior to death?	completion	of cause of
g		Be Co	25. Was case referred to medica						26. Plac	e of Deat	1 ☐ Yes		1 10 16	s 2 No	
\geq	> 0 0	To B	examiner? 1 ☐ Yes 2 🔯 No	Hospital: 1 2	Ínpatient	2 ER/Out	tpatient 3	3□ DOA Oth	er: 4 □ N	lursing Ho	me 5 Res	idence (3 ☐Other (Sp	ecify)	
n ot	ding Ph h. After thi funeral		27. Manner of Death 1	28a. Dat	e of Injury onth, Day Y	'ear) 28b. T	Time of njury	28c. Injun Wor			28d. Describe	how injur	y occurred		
S	Attending or death.	cati	2 Accident investi	gation not be					Yes 2]No	001 11	/O	444		
Division	ii or Attend after death i Director: / d in by the f	Certification:	4 Homicide determ	sined 289. Pla	ce of Injury Iding, etc. (- At home, fai (Specify)	rm, street,	factory, office			28f. Location City or To			Hurai Houte n	vumber,
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi		29a. Certifier 1 ☐ Certifyin (Check only 2 ☐ Medical	ng Physician: To t Examiner: On the	he best of a	my knowledge	e, death oc	curred at the tin	ne, date a	ind place,	and due to the	cause(s)	and manner	as stated.	se(s)
	the H	Medicai	one) 29b. Signature and title of certific	and ma	anner state			29c. Licens					e signed (Mo		
			> Received	was or	الم	CAC		D 20					_	2006	
	10		30. Name and address of person								- 1				Mil
			D N MTCDA M D	7229 HANOV	ER PKW	Y CREEI	NBELT	MARYT.ANI	D 2077	0					
		ate	31. Date filed (Month, Day, Year		Redistrar's	s Signature	A ST	all 9							
	Regist	rar	MAY (18 SOUP	MALU	and he	1								

Amended Item 16a per F.D. & Item 26 per Physician 05/05/2006 Carroll County, wjl
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Maryla		artment of He rtificate of D			leg. No.	16075
			Decedent's Name (First, Middle, Last	t)				2. Date of Dea Month	th Day Year	3. Time of Death
	Physicia /Medic	_	Betty J. M	alone				05	03 200	
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or			4c. County of Dea	
1			6124 Quinn Or	chard Road		Frede		o Dava d Disab	Freder	
	Funeral		5. Social Security Number 6. S	TH OFF	rs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	7, Year) 8, 1925	thplace (State or Foreign ountry) PA
	Director	-	219-12-2279 Usual Residence of Decedent	80				001.2	0,1923	1A
	land ow	ľ	10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Man)	į	PA Adams		Littl	estown				1 Tyes 2 No
	h the	ie	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	23a (ai	1224 B White			1734		<u> </u>	USA 14. Race - Am	odono Indian
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "netural", or items 23a or 28e-f show or other treumatic event, the Medical Examera	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 9 2		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No		erry Yes or No- tican, etc.)	Specify:	
5-0036	2 hou	ted	15. Decedent's E	ducation		dent's Usual Occupa	ition		16b. Kind of Business	/Industry
215	within 73 ene. than "n	pie	(Specify only highest gra		2 life	dent's Usual Occupa kind of work done d DO NOT use retired Legistered	Nurse	9		
2121	filed with Hygiene ther the	Be Completed			² 1	legister	Nurse		<u>Health (</u>	Care
pu	be file d oth	Be	17. Father's Name (First, Middle, Last,				18. Mother's Name		seller	
yla	ould Men Parke	2	Walter Smith	Time Defeat	10h Maili	na Address (Street a			r, City or Town, State,	Zin Code)
Maryland	12 sho h and 7 Is mu treum		19a. Informant's Name/Relationship (_	2010/00/00/00	4	aproperties appeared	22-010-04		.PA17331
	1 and 2 Health tem 27 other tr		Jeanette Hetr 20a. Method of Disposition	eck-Daughter	b. Place of Dispi	Lupoun osition (Name of	ding Dan	Road	20c. Location - City of	Town, State
Ď	ages int of t: If it		1 Ø Burial 2 Ø Cremation 3 € '4 Donation 5 Other (Special			matory or other place JCC_Ceme		6/06	Taney	town,MD
Baltimore,	permit. Pages Department of Importent: If ii any injury or o	3	21. Signature of Euneral Gervice Lice			2. Name and Addres				17340
B	permit. Departr Importe any inje	y v	Ruhand	Loule 1					ve.Little	estown,PA
1	Physician /Medical Examiner	8 5	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the cone cause on each line. a	CARCI		g, such as cardiac or		rest,	Approximate Interval Between Onset and Death
•	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a con	sequence of):					
68760,	icate be executed physician and s the burial-transit	edicai Exa	that initiated events resulting in death) Last	Due to (or as a cor	sequence of):					
		ledi								
O. Box	The law requires that the death certifi tte has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (s <i>pecify)</i>			23d. Date of de Month	olivery Day Year
ds, P.O.	uires that the d signed by the lid be detached	þ	Part II. Other significant conditions	contributing to death but no	t resulting in the	underlying cause give	en in Part I.		obacco use contribute ⁄es 2∰No 3□F	o the cause of death? Probably 4 Unknown
Division of Vital Records,	The law requir te has been si age 2 should l	Completed				·			osy prior to rmed? death?	utopsy findings available completion of cause of
ita		Be C	25. Was case referred to medical examiner?				26. Place of Death			Daughter's
<u>></u>	hysic his ce Il dire	2	1 ☐ Yes 25 No		2 ER/Outpatie		4 Nuising Hon		dense 6 Other (Sp.	ecity) Residence
u	ding Phys n. After this funeral di	on:	27. Manner of Death 1	28a. Date of Injury (Month, Day Yea	ar) 28b. Time (Worl	/a(⟨? Yes 2 □No	:8d. Describe r	low injury occurred	
Divisio	or Attending Physicien: after death. Director: After this certificd in by the funeral director. I	Certification;	2 Accident investigation 3 Suicide 6 Could not lead determined 4 Homicide determined	De Disco of Injunt	At home, farm, s pecily)			28f. Location (S City or Tox	Street and Number or F vn, State)	Rural Route Number,
_	To the Hospitel or Attenwithin 24 hours after deall To the Funerel Director: completely filled in by the	Medical Co	29a. Certifier 12 Certifying P (Check only 2 Medical Exa	hysician: To the best of my miner: On the basis of exa and manner stated.	rknowledge, dea mination and/or i	th occurred at the tin	ne, date and place, a pinion, death occurre	and due to the	cause(s) and manner a date and place, and du	is stated. le to the cause(s)
	ro the vithin o the comple	Me	29b. Signature and title of certifier	\		29c. License			29d. Date signed (Mor	- 1
	N		Kaynow E	a Mathers	, mo		6880 E		May 4,	2006
	Mis		30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print) R. ERI 795	CHERM TRO	E COURT	- Itamvar	PA 17331
	St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 5	32. Registrar's S		Society)				

		1	For Stata Registrar	State of Maryland / Do	epartment of Hea Certificate of De		ntal Hygiene Rag. No	Z1111b	16076
	Q		1. Decedent's Name (First, Middle, Last)				Date of Death Month Da	y Year	3. Time of Death
	Physicia /Medic		Mildred Masa	nvi		N	lay 5	2006	2:15 P M
	Examin		4a. Facility Name (If not institution, give str	eet and number)	4b. City, Town, or Loc	ation of Death		. County of Death	
ı			19801 Bramble Bush			ersburg Under 24 Hrs. 8	Date of Birth	Montgome	ry place (State or Foreign
	Funeral		5. Social Security Number 6. Sex 1 □ N	7. Age (In yrs. last birth		lours Min.	(Month, Day, Year,) Cou	pabwe
	Director	-	None Usual Residence of Decedent			D	ec. 25,19	939 211111	Jabwe
	/land		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Man.	to	MD Montgom	ery	Gaithersbur	g			1 ☐ Yes 2 🙀 No
	or 28	Director	10e. Street and Number		10f. Zip Code			tizen of What Cou	ntry?
	23a (23a)	al	19801 Bramble Bu			20879		imbabwe	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "ratural", or items 23a or 28a-1 show any injung ogother traumette event, the Medical Erran and the notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispar If Yes, specify Cuban, N 1 ☐ Yes 2 █ No S	nic Origin? (Specify lexican, Puerto Rica pecify:	y Yes or No- an, etc.)	14. Race - Ameri Black, White Specify: B	
Ö	2 hou	ted	15. Decedent's Educa (Specify only highest grade		Decedent's Usual Occupation (Give kind of work done durin	n most of working	16b. I	Kind of Business/Ir	ndustry
215	thin 7 e. an "r	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	•		O II	
7	ed wi	Completed	12		Homemaker	. Mother's Name (F	iret Middle Maide	Own Home	
nd	be fill d oth evan	Be	17. Father's Name (First, Middle, Last) Ernest Mutandwa	Madekufamba	16.	•	Nemunyad		
<u> </u>	d Mer d Mer narke	T _o	19a, Informant's Name/Relationship (Type		Mailing Address (Street and				p Code)
, Maryland	and 2 st ealth and n 27 Is r		Ida Maindidze / D	aughter 19	801 Bramble E		e, Gaithe		MD 20879
altimore,	Pages 1 nent of He int: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	cemetery	Disposition (Name of v, crematory or other place) District Cemetery	May 17 2006		akoni Dis Zimba	trict
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service Licenses	_	22. Name and Address of Deer Park Dr			-	
1	Pnysician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death. Do no		uch as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of					
	Examiner		Sequentially list conditions, b.	Metasta	tic Cancer -	Uncertain	n Primary	7	1 Month
	7 # #	iner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	f):				
	be executed ician and burial-transit	Examine	that initiated events c. resulting in death) Last	Due to (or as a consequence of	of):			-	
8760,	be ex ician burial								
387	icate be executed physician and s the buriat-transit	dic	d.				2.221		
.O. Box 6	at the death certificate by the attending phys tached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deli Month	very Day Year
<u>α</u>	es that thighed by be detact	by Ph	Part II. Other significant conditions cont	ributing to death but not resulting in	the underlying cause given i	in Part I.			the cause of death?
ord	w require been si should b		Cervical Cancer				TL Yes	21 <u>A</u> NO 3[]FN	
I Records,	The lar ate has page 2	Completed					24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ N	prior to death?	topsy findings available ompletion of cause of
Vital	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	ospital:	Other	6. Place of Death (C			- N
of	Physic this c	9	1 ☐ Yes 2 🛣 No	1 Inpatient 2 ENOU	tpatient 3 DOA Time of 28c. Injury at	4 Nursing Home	 Residence Describe how in 		ify)
	ing After une	lon	1 XNatural 5 ☐ Pending		njury Work?	s 2 🗆 No		.,	
isic	Attanding r death. ector: Afte by the fune	ical	3 Suicide 6 Could not be	28e. Place of Injury - At home, fa			. Location (Street		ral Route Number,
Division	l or Attand after death Director: ,	Certification:	4 Homicide determined	building, etc. (Specify)	,		City or Town, Sta	ite)	
_	Hospite 4 hours Funerel	edical C	29a. Certifier 1X Cartifying Phys (Check only one)	ician: To the best of my knowledge ar: On the basis of examination and and manner stated.	e, death occurred at the time, d/or investigation, in my opini	date and place, and ion, death occurred	d due to the cause at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	To tha within 2 To tha	Me	29b. Signature and title of certifier		29c. License n	umber	29d. C	ate signed (Month	n, Day, Year)
			Ih M.D.		MI	D 33253	Ma	ay 8, 200	06
	2		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print)				
			Jonathan A. Cosin	M.D., 110 Irving	g Street N.W.	, Washing	ton DC 20	0010	
		ate	31. Date filed (Month, Day, Year)	32. Pagistrar's Signature	South				
	Regist	trar	MAY 09 2	uuu para su	17				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	Clare of Maryla	Cei	tificat	e of Dea	ath		ag. No.	10077
		Decedent's Name (First, Middle, Last)			-			2. Date of Deat Month		3. Time of Death
Physic		Wanda Marian McI	Roberts					May	07 700	
/Med Exami		4a. Facility Name (If not institution, give s			4b. City,	Town, or Loca	tion of Death		4c. County of De	ath
AGIII		PENINSULA REGION OF	medicae o	CENTU		SALI	sky		NI	COMICO
Funera Directo		5. Social Security Number 6. Sex 218–16–6567	M 2XF 7. Age (In yr	s. last birthday) Yrs.	If Unde Months		nder Hrs. urs Min.	8. Date of Birth (Month, Day, 2/23/1	Year) (rthplace (State or Foreign country) MD
D		Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo	cation					10d. Inside City Limits
ne Mary 8a-f sh	ector	MD Worcest	er	Snow Hi	-				0-03	1 ☐ Yes 23 € No
h with th	ai Dire	10e. Street and Number 7742 Cedartown Rd			10t. Zij	21863	3	1	0g. Citizen of What 0	ountry?
be filed within 72 hours after death with the Maryland hat hygiene then "natural", or Iteme 23e or 28e-1 show event, the Medical Examinar matter the notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Xividowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			dent of Hispani only Cuban, Me		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
nin 72 ho n "natur Nedical	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of wo	al Occupation ork done during se retired)	most of work	ing	16b. Kind of Busines	s/Industry
nd 2 should be filed within 72 hours aft lits and Mental Hyglene. 27 is marked other than "naturel", or traumatic svent, the Mudical Exert	Com	11 17. Father's Name (First, Middle, Last)	Conege (1-401 3+)		Home	maker	Mother's Nam	e (First, Middle, M	Own Home	2
d be ontal	Be	Clarence Hasting	7.6				Annie	Truitt		
should ind Men marke	2	19a. Informant's Name/Relationship (Ty)		19b Mailir	na Addres	s (Street and N			City or Town, State,	Zin Code)
d 2 s th an 7 is		Dale McRoberts	,		-				, MD 21863	
Head the street		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ R	emoval from State	Place of Dispo cemetery, cres ape Hen	sition (Na	me of other place)		Date	20c. Location · City of Frankford	r Town, State
permit. Pages 1 a Department of Her important: If Item any Injury or othe		4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Service License		22	. Name a	nd Address of F	acility The	Burbag	e Funeral	
40.54		23a. Part1. Enter the disease, or complishock, or heart failure. List only on	lake					Berlin, 1		Approximate
Physician / Medica Examines be executed Examines be being bubbicien and es the burial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Socialities if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons End Sto Du ras a cons Due to (or as a cons	equence of):	en a	D al f	Failo	FC.		Onset and Death
death cer e attendir od for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	Ectopic p				23d. Date of d Month	alivery Day Year
uires that signed b	5	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying	cause given in I	Part I.			to the cause of death? Probably 4 冠Unknown
The law requires that the rate has been signed by the page 2 should be deteched	Completed							24a. Was a autops perform	y prior to ned? death?	
lan: rtifice stor, 1	Be	25. Was case referred to medical examiner?				26.	Place of Deal	h (Check only on		
ng Physician: Titer this certificat	2	1 Pending 1 Pending 1 Pending	ospital: 1 🔀 Inpatient 2 28a. Date of Injury (Month, Day Year)			OA Other: 4	□ Nursing Ho		once 6 Other (Sp ow injury occurred	ecify)
or Attending after death. Director: After	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · Albuilding, etc. (Spe	t home, farm, str cify)	M reet, factor	1 ☐ Yes	2 □ No	28f. Location (St City or Town	reet and Number or I n, State)	Rural Route Number,
To the Hospital or Atterview within 24 hours after de To the Funeral Direct completely filled in by the	Medical C		sician: To the best of my kiner: On the basis of examinand manner stated.							
ithin ;	Me	29b. Signature and title of certifier			29	c. License num	ber	2	9d. Date signed (Mo	nth, Day, Year)
with To		1 Aoman	^			1)618	32.7	,	5/7/01	5
- 17		30. Name and address of person who co	mpleted cause of death (I	tem 23a) (Type,	Print)					
15		Sivakumar Raman,			St.,	Salish	oury, N	ID 21801		
S Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	land	,				

DHMH 17 Rev 1/2001

Wanda McRoberts 218-16-7857

anor Nurs	street and number) sing Home x 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yrs 7. Age (In yr	i. last birthday) Yrs. City. Town or Local	Hage If Under 1 Year Months Days eation Durg	r Location of Death Prstown If Under 24 Hrs. Hours Min.	2. Date of Dea Month May 8. Date of Birtl (Month, Day Aug. 8	Day Year 9 2006 4c. County of Dea Washingt	
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anor Nurs 6. Sei 476 Decedent 10b. County Montgom ber ng James d 2 Married Divorced 15. Decedent's Edd y only highest grad	ing Home 7. Age (In yrs 79 10c. C 10c. C 12. Was Decedent Ever in tagents of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the	Yrs.	Hage If Under 1 Year Months Days eation Durg	rstown If Under 24 Hrs.	(Month, Day	Washingt h , Year) 9. Bii	
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Montgom ber ng James d 2 Married Divorced	Way 12. Was Decedent Ever in I		ourg			1926 I	llinois
Montgom ber ng James d 2 Married Divorced	Way 12. Was Decedent Ever in I		ourg				10d. Inside City Limit
ng James d 2 Married Divorced 15. Decedent's Eddy only highest grad	Way 12. Was Decedent Ever in U	aithersb					1 ☐ Yes 2 ☑ N
ng James d 2 Married l Divorced 15. Decedent's Eddy only highest grad	12. Was Decedent Ever in U Armed Forces?						
d 2 Married I Divorced 15. Decedent's Edu y only highest grad	12. Was Decedent Ever in U Armed Forces?		10f, Zip Code			10g. Citizen of What C	ountry?
d 2 Married I Divorced 15. Decedent's Edu y only highest grad	12. Was Decedent Ever in U Armed Forces?		20779)		USA	
Divorced 15. Decedent's Edu y only highest grad		U.S. 13. W	Vas Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Whi	
15. Decedent's Edu y only highest grad	1 ☐ Yes 2X No	i	☐ Yes 2X No	Specify:	1110011, 0101,		
y only highest grad	If Yes, Give Year or Dates:	'	□ 195 20 140	эрвспу.		Specify: Wh	nite
	ucation	16a. Decede	ent's Usual Occup	ation during most of work	ring	16b. Kind of Business	:/Industry
daily (O-12)	College (1-4or 5+)	life. D	OO NOT use retired	during most or work	ing		
	2	Hon	nemaker			Her own h	iome
First, Middle, Last)	1 - 1			18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
aylor				Margaret	Stellwa	ag	
me/Relationship (T)	una Print)	19h Mailing	n Address (Street			ar, City or Town, State,	Zip Code)
			•			ederick, Mo	
<u>ooke – Da</u>	ughter				Date	20c. Location - City of	
osition	Removal from State	cemetery, crem	sition (Name of natory or other place	ı			
5 ☐ Other (Specify)		gerstow	n Cremat	ory 5/11	L/06	Hagerstown	, Maryland
neral Service Licens	see	22.	Name and Addre	ss of Facility	Minnich	Funeral Ho	ome
TO S	landin	4	15 E. WI	Ison Blv	d. Hage	erstown, Md	1. 21740
e disease, or comp	olications that coused the dea	ath. Do not ente	er the mode of dyin	ng, such as cardiac			Approximate Interval Between
rraliure. List only o Final	one cause on each line.	~					Onset and Death
_	a. 7971	ح ۔					WEEKS
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ditions,	b. Due to for as a conse	augree of)	744	Fa-lue			
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	d						
pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy	,		23d. Date of de	
months?	4 Pregnant at time of		Other (specify)	<u></u>		Month	Day Year
	9□ Unknown						
cant conditions or	ontributing to death but not re	esulting in the un	derlying cause giv	en in Part I.	23e. Did to	obacco use contribute t	to the cause of death?
betu	Melli Nus				101	/es 2 □ No 3 □ P	robably 4 Unknow
2 avy	artuy obs	ealer			04- 146-	O4b 14/	
					24a. Was autop		autopsy findings availab completion of cause o
0					1 Yes	2 1 No 1 □ Ye	s 2 No
ed to medical				26. Place of Dea			
No	Hospital: 1 ☐ Inpatient 20	☐ ER/Outpatient	t 3 DOA Oth	er: Nursing H	ome 5 Resid	dence 6 Other (Spe	ecity)
1	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injur Wor			now injury occurred	
5 Pending investigation		Injury		Yes 2 □ No			
_		home, farm, stre	eet, factory, office			Street and Number or F	Rural Route Number,
6 ☐ Could not be	building, etc. (Spec	city)	, , ,		City or Tox	vn, State)	
6 Could not be determined							- state of
determined	niner: On the basis of examin	nowledge, death nation and/or inv	i occurred at the tif restigation, in my c	me, date and place. ppinion, death occur	red at the time,	cause(s) and manner a date and place, and du	is stated. le to the cause(s)
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determined Certifying Phy 2 Medical Exam			10	11112		-1 -1	
determined Certifying Phy Description of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the cont	7		w ·	100005	1	5/10/	06
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	Medical Exan	Medical Examiner: On the basis of examinand manner stated.	Medical Examiner: On the basis of examination and/or invand manner stated.	Medical Examiner: On the basis of examination and/or investigation, in my or and manner stated. 29c. Licens	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated. 29c. License number	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated. 29c. License number	

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			For State Registrar	tate of Maryland		artment o			Reg. No.	006	16079
	Dhuaicia		Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic	al -	Mary Francis McQuay					May	3	2006	4:40 P M
	Examin	=1	4a. Facility Name (If not institution, give stre	et and number)		- "	n, or Location of De	ath		County of Death	
			403 North Street 5. Social Security Number 6. Sex	7. Age (In yrs. last	t hirthday)	Elkt If Under 1 Ye		S. 8 Date of Birt		ecil	place (State or Foreign
	Funeral Director		218-22-4102	2K) F 80		Months Da			y Year)	26 Chos	place (State or Foreign intry) apeake City
			Usual Residence of Decedent			l		THOUGHT 2	-0,17	Mary	Kand
	yland		10a. State 10b. County	10c. City, T	own or Lo	ocation					10d. Inside City Limits
	B Ma	cto	MD Cecil	Elk	ton						1 ☐ Yes 2X No
	ith th	Director	10e. Street and Number			10f. Zip Cod				en of What Cou	intry?
	ath w	rai	403 North Street		10	2192		(0	us	A 4. Race - Ameri	ince Indian
	er de Items	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo	13.	If Yes, specify (of Hispanic Origin? Cuban, Mexican, Pu	erto Rican, etc.)	-	Black, White	
36	Irs aft	by	3 □XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢	No Specify:			Specify: W	hite
21215-0036	72 hours after death with the Maryland Instural; or ttems 23a or 28a-f show Jisal Ezairi ar must te todified at	ted	15. Decedent's Educat		16a. Dece	dent's Usual Oc	cupation		16b. Kin	d of Business/Ir	
215	within 7 ene. than "n	pje	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	one during most of w tired)	orking			
2	filed withi Hygiene. other than	Completed	12		Ho	memaker				n Home	
pu	tal Hy d oth even	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle,		Sumame)	
yla	should be nd Mental marked o	၉	David Seacord 19a. Informant's Name/Relationship (Type.	Dried)	10b Mail	m- Addross /Ct		B. Conne		Tour State 7	in Code)
Maryland	d 2 sho		Peachie M. Reese/dau				reet and Number or			TOWN, State, ZI	p code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avent, the Medical Evaluation or colling at	1	20a. Method of Disposition	20b. Plac	e of Dispo	osition (Name o	Street,	Date		1921 ation - City or T	own, State
lo I	00		1 Burial 2 Cremation 3 Rem '4 Donation 5 Other (Specify)	oval from State	-	matory or other 2metery	· · · · · · · · · · · · · · · · · · ·	08-2006	Chos	anaaha	City MD
Baltimore,			21. Signal re o Funeral Service Licensee	1 Decin			ddress of Facility R				
Ba	permit. Departr Imports any inji		Kuchard of	Goodie		318 Ge.o.	rge Stree	t. Chesan	noabo	Citu	MD 21915
	-6.		23a. Part1. Enter the disease, or complicate shock or heart failure. List only one	ions that caused the death.	Do not en	ter the mode of	dying, such as card	iac or respiratory a	rrest,	C.C.Ly	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Passinah		-	+				Onset and Death
	/Medical		resulting in death)	Due to (or as a consequen	nce ii):	CVICS	•				
	Examiner		Sequentially list conditions, b	Advonce	2	100 CE	ncer				
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	nce or):	0					
_	and and II-tran	хап	that initiated events c resulting in death) Last	Due to (or as a consequer	nce of):						
190	te be executed ysician and ne burial-transit	ā									
687	o y	edic									
Вох	death certificat e attending phy ed for use as th	In/M	23b. was decedent pregnant	If yes, outcome of pregnanc		⊒Ectopic pregn:	ancy		2;	3d. Date of deliv	•
	0 0 0	Physician/Med	in the past 12 pronths? 1 ☐ Yes 2 No	4 Pregnant at time of deal		Other (specify				Month	Day Year
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	og og	by	Part II. Other significant conditions contri	outing to death but not resulti	ng in the u	underlying cause	given in Part I.	23e. Dia ti	2.4	ie contribute to ÎNo 3 ☐ Pro	the cause of death?
Records,	v requir been si should	Completed	Gera					-			
ec	law nasb e 2 sl	npie						24a. Was	an osy ormed?	24b. Were aut prior to co death?	opsy findings available empletion of cause of
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	pital:			Othor	eath (Check only o			
o	Phys	. To	T Yes 2 No	1 Inpatient 2 EF	VOutpatie 8b. Time o		4 🗆 140121110	Home 5 Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resid		Other (Speciocourred	(fy)
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Division	Attending ir death. ector: After by the fune	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At hom	e, farm, st	reet, factory, off	lice			Number or Rui	al Route Number,
D.	al or after	Certification:	4 Homicide	building, etc. (Specify)				City or Tov	wn, State)		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical ((Check only 2 Medical Examine	ian: To the best of my knowle : On the basis of examination							
	tha hin 24 the F	Medi	one) 29b. Signature and title of certifier	and manner stated.		29c 1 i	cense number		29d Date	signed (Month	Day Year)
	To To	-	29b. Signature and title of certifier	(1)							
			Consideration	plated source of do-st-file-	20) (T:-			30	7		
	6		30. Name and address of pe who com	Source of death (Item 2	,UD	دد"".	13 4	Main	54	ELK	of mmD.
	Sta	te	31. Date filed (Month, Day, Year) 8 2	32. Flagstrar's Signatur	re H	Angel.	,				
	Regist		MAIUOZ	006 Millian	10.	A STATE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PAR					

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	4	(m	Decedent's Name (First, Middle, Last)	2. Date	of Death	3. Time of Death
	Physi /Med		Ralph Andrew Murphy	Mar		, 0306 AM
	Exam		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or	Location of Death	4c. County of Dea	th
_		8.2		l Air	Harford	
	Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 214-32-2845 88 Yrs. 88	Hours Min. Aug.	th, 2 ^{ay,} 49817	hplace (State or Foreign ountry)
		'	Usuaf Residence of Decedent		Mar	/land
	C 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28e-f ehow int, the Markal Examinar must be pourfied at	5	10a. State 10b. County 10c. City, Town or Location Bel Air			10d. Inside City Limits
	the 7	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?
	h with	a D	615 Weatherby Road	21015	USA	J
5	deat	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His Armed Forces? 15. Was Decedent of His	ispanic Origin? (Specify Yes in, Mexican, Puerto Rican, et	or No- 14. Race - Ame	
0306 an	36 s after or It	by Fu	1 Never Married 2 Married 1 X Yes 2 No	Specify:		hite
9	hours tural:	Q p	Wildowed 4 □ Divorced Year or Dates: WW2 15. Decedent's Education 16a. Decedent's Usual Occupa	ation	16b. Kind of Business.	
00 ;	115- in 72	plete	(Specify only highest grade completed) (Give kind of work done d	during most of working	IGD. KING OF CUSINESS.	modeliy
	21215-0036 d within 72 hours af giene. or than "natural", or than Modfell Exercit	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 Consequence College (1-4or 5+)	Operator	Yough Moto	or Co.
2	be filed ntal Hygi	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, N	fiddle, Maiden Sumame)	
	arylan should be and Mental marked o	To	Quincy A. Murphy	Mary Martha		
	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		19a. Informant's Name/Relationship (Type, Print) Frank Jankowiak, Son-in-law 1610 Prindle I			Zip Code)
0	s 1 and 3 frem 27 other tra		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or	Town, State
0	Pages nent of nnt: If It		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		Friendsvil	Le, MD
2/10/0	Baltimo permit. Page Department of Importent: If any Injury or				Funeral Homes, Grantsville	
)	4.0		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or hear/failure. List only one cause on each line.	g, such as cardiac or respira	tory arrest,	Approximate Interval Between
	Physicia	n	Immediate Cause (Final disease or condition a CARDIAC ARRHYT	HMIA		Onset and Death
	/Medica	1	resulting in death) Due to (or as a consequence of):	77777		
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360000	8 760, cate be executed physicien and the burial-transit					
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\mathcal{Z}	I Records, P.O. BOX 61 The law requires that the deeth certific ate hes been signed by the attending p page 2 should be detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of del	ivery
#800	deeth deeth deeth deeth deeth	S	in the past 12 months? 1 Yes 2 No 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
#	P.O. that the digital by the detached	hys	9 Unknown			
Z	S, Fres the	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I. 23e.	Did tobacco use contribute to	
2	w requir	ted			1 Yes 2 No 3 Pr	obabfy 4 Unknown
26	ec taw taw nes b	Completed		24a.	Was an autopsy 24b. Were au	topsy findings available completion of cause of
2	The cate he page	Co		10	performed? death? Yes 2⊠No 1⊟Yes	2 □ No
()	Vital vicion: Certifica rector, p	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death Check		
3	Phys Phys ral dir	-T	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA	· Directing ricine	Residence 6 Other (Specified how injury occurred	cify)
P	ding h.	ton	1 Naturat 5 Pending (Month, Day Year) Injury Work	(? Yes 2 □No	silve flow injury occurred	
Q.	VISION Of VITAI Attending Physician: or death. •ctor: After this certification by the funeral director.	fica	3 Suicide 6 Could not be	28f. Loca	tion (Street and Number or Ru	ıral Route Number,
Mr	E Signal	Certification;	4 ☐ Homicide determined building, etc. (Specify)	City	or Town, State)	
		edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the tim (Check only one) 2	ie, date and place, and due to pinion, death occurred at the	o the cause(s) and manner as time, date and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier 29c. License	number	29d. Date signed (Mont	n, Day, Year)
			Pletrucia guy ma 126	344	11/14/10,2	1006
			30. Nam and address of person who completed cause of leath (Item 23a) (Type, Print)	1 A Ra	1 l'amo	01011/2
	100		Patrica Gruny 500 Upor Chesaplat 31. Date filed (Month, Day, Year) 32. Registrar's Signature	eur te	2411,1010	4014
	Regi	state strar	MAY 1 2 2006			,

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sally Ann McKenzie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01 If Under 24 Hrs. 8. Birthplace (State or Foreign Country)
 Maryland Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1□M 2XF 215-42-4599 Yrs 63 December 02, 1942 Director Usual Residence of Decedent with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Cordova Director Talbot Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21625 9901 Councell Road or Items 23a death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filled within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or Item 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify 2 3 Widowed 4 Divorced White Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be **Edward Francis Armstrong** Florence Elruthie Hall 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9901 Councell Road, Cordova, Maryland 21625 Ernest Getson-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition May 07. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State The Cumberland Crematory 2006 Cumberland, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Faction Eichhorn-McKenzie Funeral Home P.A., 8 East Main St., 21. Signature of Funeral Service Licensee Mares 2. Lonaconing.Md. 21539 23a. Part. Enter the disease, or complicate as that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DUSOST /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-transit Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 should be 1 Tyes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has 2**2** No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death Check only one examiner Hospital: Other: 1 ☐ Yes 2 No 1/2 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA Pis After this funeral c 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Cirector: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) n by 4 Homicide within 24 hours a 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier months who completed cause of death (Item 23a) (Type, Print) MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 0.5 07 2006 **Physician** 6:50 PM MARGARET ANNE MERRILL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Snow Hill Nursing & Rehabilitation Snow Hill Worcester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 9/10/1920 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 M XXF Maryland 85 216-40-4239 Director Usuel Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County , or Items 23s or 28s-f show the Medical Examiner must be notified at 1 1 Yes 2 □ No Snow Hill MD Worcester Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21863 USA 430 West Market Street death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No filed within 72 hours after 1 Never Married 2 ☐ Married 1 ☐ Yes 💥 No Specify: Baltimore, Maryland 21215-0036 Specify: White ۵ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Domestic other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Depertment of Health and Mental Hy Importent: If Item 27 Is marked oth any fujury or other treumatic event ORB. Be H. Merrill Virginia Benson Upshur 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Virginia B. Nelson/ Cousin 205 W. Martin St., Snow Hill, MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 5/10/2006 Pocomoke, MD Pitts Creek Presbyterian 4 ☐Donation 5 ☐ Other (Specify) 21. Surveye of Funeral Service Licensee 22. Name and Address of Facility Holloway Melson Funeral Home, Professional Association 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CORONARY ATHEROSCLE 2051S **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physician/Medical as the IF FEMALE: 950 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 10 No 1 ☐ Yes Division of Vital funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of After 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1D Certifying Physician: To the best of my knowledge, death occurred at the time, that and blace, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5/8/2006 M.D. 00062172 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1604 MARKET ST. POLOMOKE CITY B.A. 2 R SATYAL, MI) egistrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

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Division of Vital Records, P.O. Box 68760 page 2 s rector, eral dir il: After Director: À 24 hours

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28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 29a. Certifie 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1, 2006 D13231 MAY romas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785 THOMAS PINDER M.D. 31. Date filed (Month, Day, Year)

2 ER/Outpatient

26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 Other (Specify)

Other:

3 DOA

State Registrar

MAY 0 5 20.06

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death



1 XInpatient

		_	For State Registrar	State of Mary		artment of H			giene 0 0 6	16085
	Physicia	an	1. Decedent's Name (First, Middle, Last)	lann Tr				2. Date of Dea Month	Day Year	3. Time of Death 10:35 A. M
E	/Medic Examin	er	Marshall Thomas M			4b. City, Town, o			4c. County of Dea Allegany	th
	Funeral		13603 Mann Road, N 5. Social Security Number 6. Sex	7. Age (Ir	n yrs. last birthday)		If Under 24 F	lin. 8. Date of Birtl (Month, Day August 0/	h 9. Bir	thplace (State or Foreign buntry)
	Director		Usual Residence of Decedent		79 ^{Yrs.}			August 07	,1926 Pin	ey Grove, MD
	Marylan -1 ahow Ied at	tor	10a. State 10b. County MD Allegany		oc. City, Town or Lo Little Or					1 🗌 Yes 2 No
	or 28a	Direc	10e. Street and Number		10010 02	10f. Zip Code			10g. Citizen of What Co	ountry?
. 98	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 ahow other transmeter than "natural", or items 23a or 28a-1 ahow other transmeters of the Medical Exeminer must be notified at	by Funeral Director		E 2. Was Decedent Eve Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		21766 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 21 No		(Specify Yes or No- uerto Rican, etc.)		
Baltimore, Maryland 21215-0036	hin 72 hou s. in "natura Medical E	Completed	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of	working	16b. Kind of Business	
121	iled with Tygiene ther the nt, the	Com	17. Father's Name (First, Middle, Last)		Truc	k Driver	18. Mother's	Name (First, Middle,	Propane De	livery
/lanc	uld be f Mental I Irkad ol	To Be	Marshall Mann, Sr.					a C. Chamb		
Man	id 2 sho lith and 27 is ma trauma		19a. Informant's Name/Relationship (Type Betty J. Mann/Wife	e, Print)					er, City or Town, State, eans MD 21	
ore,	ges 1 ar t of Hea ff itam or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)	Date	20c. Location - City or	Town, State
altim	permit. Pages Department of Inportant: If Its any injury or of		4 ☐ Donation 5 ☐ Other (Specify) 21. Separature of Funeral Service License)amascus 2	Cemetery 2. Name and Addre			ig Cove Tan est Main St	
ä	Derm Depa impo		OK (U)	Mar	Grand Danston	ove Fune	ral Hom	e,P.A. Har	ncock,MD 21	750-0368 Approximate
	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Coron	aney (Ersery	/ 1 .	ease	1031,	Interval Between Onset and Death
	/Medical Examiner		Sequentially list conditions, b	Due to (or as a c	onsequerde of):	0				
760, /	te be executed ysician and te burial-transit	cal Examiner	if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c						
P.O. Box 68	The law requires that the death certificative tes been signed by the attending phycage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of a 1 Live birth 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 December 2 Dec	Fetal death 3	☐Ectopic pregnanc ☐ Other (specify)	у		23d. Date of de Month	livery Day Year
	uires that i signed b id be deta	þ	Part II Other significant conditions con	tributing to death but r	not resulting in the d	underlying cause giv	ven in Part I.		obacco use contribute t Yes 2 □ No 3 🗗 🏲	o the cause of death? robably 4 □Unknown
Records,		Completed	Mithal Regn Hungh wide	-gitokin	~, Hy	prlight	Lemís			utopsy findings available completion of cause of
Vital	Physician: Th this certificete ral director, pag	o Be	25. Was are referred to medical	ospital:	2 🗀 ER/Outpatie	ent 3 DOA Ott	200	Death (Check only o	one) dence 6 □Other (Spe	acity)
ion of	ing After une	IF.	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y		of 28c. Inju			how injury occurred	Sury
Division	5 # # C	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, si (Specify)	treet, factory, office		28f. Location (S City or Tox	Street and Number or R wn, State)	ural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical O	29a. Certifier 1 Certifying Physics (Check only one)	sician: To the best of r ner: On the basis of ex and manner state	xamination and/or i	th occurred at the ti nvestigation, in my o	me, date and p opinion, death o	lace, and due to the occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	0	. \	29c. Licens			29d. Date signed (Mon	
,	'n		30. Name and address of person who co	ompleted cause of dear	th (Item 23a) (Type	Print)	00 54	411	5-9-	2006
	1.2			s, M.D. 50	O Memoria	al Drive	Cumber1	and, MD 2	1502	
4	St Regist	ate rar	MAY 2 0 2	2006	a de	Cooks				

DHMH 17 Rev 1/2001

Amended Item 20b per F.D. 05/08/2006 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Lesi 1205PM Kevin Trones 0-6 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Carroll Hospital Center
5. Social Security Number 6. Sex Westminster <u>Carroll</u> 8. Date of Birth Month, Day NOV 25 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under Year) 1935 **Funeral** Months 1 M 2 □ F 70 084-28-7264 Yrs Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director MD Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21157 1606 Gable Hammer Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Amed Forces? IMYes 2□No Korean/ IfYes, Give Year or Dates: Viet Nam 1 Never Married 2 Named 1 ☐ Yes 2 No Specify: Specify: White Ď 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Carroll County Elementary/Secondary (0-12) College (1-4or 5+) Sheriff's Dept Sqt.for Road Crew 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Alice Kennedy Patrick Joseph O'Leary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 is any injury or other traisonce. 1606 Gable Hammer Road Westminster, MD Marie Diane O'Leary/wife 21157 20b. Place of Disposition (Name of Mtcem@ViceptoryGemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Oliviet Cometery 5/8/2006 Hanover, PA 22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help failure. List only one cause on each line. 21157 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Curuns Due to (or as a consequence fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 2 100 1 ☐ Yes 25. Was case referred to medical Be 26. Pface of Death (Check only one) Hospital: 1 ☐ Inpatient 2-DER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records,

and Mental Hygiene.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funerat Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use so the burlat-transit completely filled in by the funeral director, page 2 should be detached for use so the burlat-transit

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1. Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

4 | Homicide

(Check only one)

29a. Certifier

Medical

State

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

MAY 0 8

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print

Sittershi

31. Date filed (Month, Day, Year)

32. Registrar's Signature 2006

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29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 29b. Cignature and title of certifier 29c. License number 29d. Date signad (Month, Day, Year O.C.M.E. May 9, 2006	Recor		performe	ed? death?						
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	F 3 F 8	Patulionica-folders O.C.M.E.			nth, Day, Year)					
Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	r	30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimor	re, MD 21201							

State 31. Date filed (Month, Day, Year) MAY 1 6 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#PII, 25, 27, 28-f. 29a, per ME, 2856, 6/23/06 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2006 11:59 P Russell O'Haver <u>May 1</u> Robert /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Mercy Medical Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Min. 1♥M 2□F 523-22-3856 Yrs Oct. 2, 1926 Colorado Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes XXX No Columbia Director Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21044 USA 6500 Freetown Road by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: Specify: White WII 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FBI Exhibit Specialist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marguerite Penaluna Thomas D. O'Haver 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6500 Freetown Road Columbia, Maryland Mary O'Haver / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Page Department of Importent: If any injury or once. May 5, 2006 Clinton, Maryland Resurrection Cemetery 21. Signature Funeral Service Licenses 22. Name and Address of Facility 6160 Oxon Hill Road Oxon Hill, Waryland 20745 al 10 Approximate Interval Between Onset and Death HOURS 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ACUTE RESPIRATORY FAILURE **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner DAYS PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No XX Probably 4 Unknown End Stage Renal Disease 24b. Were autopsy findings available prior to completion of cause of death? Hypertension autopsy performed? 1 ☐ Yes X X X No Right Acetabular Fracture 2XXNo 25. Was case referred to medical examiner?
1. Yes 2 No. 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 🕱 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1X Natural 1 ☐ Yes XX No investigation April 2006 unk subject fell 2 X Accident 3 Suicide 6 Could not be determined 281 Location (Street and Number or Rural Route Number, City or Town, State) 6500 Freetown Road Apt 205 Columbia, MD Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Hame Apt 205 Columbia, 架文Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifie D0061429 May 2, 2006

DHMH 17 Rev 1/2001

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

and

the attending physician

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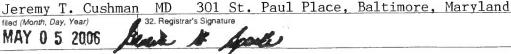
Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.

wer, If item 27 is marked other then "natural; or Items 23a or 28e-f show may no fother than the indifferal may or other transatic event, the Medical Examples must be notified at

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) MAY 0 5 2006



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artme <i>tifica</i>	nt of H	ealth and Death	d Ment		iene 2 ()	06	16089
Ş	Dhysisi		1. Decedent's Name (First, Middle, La	st)							ate of Deat	h Day	Year	3. Time of Death
	Physici /Medic		LEAH	PEAS						MA	Y 5,	7		1:15P M
。	Examin	er	4a. Facility Name (If not institution, given FREDERICK MEMORIA	e street and nu L HOSPI	m <i>ber)</i> TAL			, Town, or DERIC	Location of De	ath		4c. County FREDE		
15.00	Funeral Director		5. Social Security Number 6. 5 577-46-3833	Sex I□M 2⊡ X F	7. Age (In yrs. 76	last birthday) Yrs.	II Unde Months	Days	If Under 24 H Hours Mi	in. (A	ate of Birth fonth, Day, ch 20	Year) , 1930	Cour	
	pu ,		Usual Residence of Decedent 10a, State 10b, County		100 0	ity, Town or Lo	antion							0d. Inside City Limits
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Baltimore,	ages ant of ht: If I		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		State	cemetery, crer ederick	-		5/8	3/200	6 _F	rederic	k M	arvland
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ouo	ding After fune	tion:	27. Manner of Death 1		ol Injury nth, Day Year)	28b. Time of Injury	М	28c. Injun Worl	/at <br Yes 2 ⊡No	28d. C	Describe ho	w injury occurr	ed	
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	V		30. Name and address of person who Ronnie L. Jacobs					erick	. MD 21	701				
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/Medio	cal	Robert J. 4a. Facility Name (If not institution		umber)		4b. City, Town	n. or Location	of Death	y 7	4c. County of D	
Examir	ner	9583 Opossumto		annoon,		Frede		o. 50a		Frederi	
Funeral Director		5. Social Security Number 213–24–8999	6. Sex 1	7. Age (In yrs. 77		If Under 1 Yes Months Day		Min. (M	te of Birth onth, Day, Yo lary 1	9. 9, 1929	Birthplace (State or Foreign Country) Maryland
and **		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
Maryi -f sho	tor	Marylnd Freder	ick		Frederi	ick					1 ☐ Yes 2 No
or 28a	Oirec	10e. Street and Number				10f. Zip Code			10g	. Citizen of What	Country?
s 23a	ral	9583 Opossum					702	0 /0 // /		U.S.A.	
be filed within 72 hours after deeth with the Maryland tal Hygiene. d other then "netural", or items 23a or 28a-f show event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 A Mari 3 □ Widowed 4 □ Divorced	ned 1 ☐ Yes	2 X No Give	'	was Decedent of f Yes, specify C 1 ☐ Yes 2	uban, Mexica	rigin? (Specify Yo in, Puerto Rican, :	etc.)		merican Indian, Vhite, etc. white
2 hour		15. Deceden	t's Education		16a. Deced	dent's Usual Occ	cupation		16	b. Kind of Busine	ess/Industry
thin 7.	Completed	(Specify only higher Elementary/Secondary (0-12)	1	(1-4or 5+)		kind of work doi DO NOT use ret		st of working			
led wi tygien her th		6 17. Father's Name (First, Middle,	(ant)		Dairy	Farmer		er's Name (First,		rming	
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is 1 and 2 should be filed within 72 hours after deeth with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene it Hem 27 is marked other then "netural", or Items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at	10	19a. Informant's Name/Relations Janet Rhinecker	hip (Type, Print)	ter	7	-	et and Numb	oer or Rural Route	e Number, C	•	re, Zip Code) 21713
s 1 and f Health Item 27 other tr		20a. Method of Disposition		1 .	 Place of Dispo	sition (Name of natory or other p	olace)	Date	200	c. Location - City	or Town, State
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permit. Pages 1 and 2 Depertment of Health a Important: If Item 27 Is eny Injury or other tre		21. Sign offe of Funeral Service	Licensee	(0)	ue 10	. Name and Add	dress of Facili	^{ity} Stauff on Pike,	er Fun Frede	eral Ho	me aryland 2170
Physician /Medical Examiner physician expectation on the private properties of the private private properties of the private private properties of the private dical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to this mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ab	o (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or as a consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) conse	quence of): quanca of):	Ca	nces	r			Interval Between Onset and Death IWGE K	
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require been sk	ted	Diabetes	mew.	tus					1 🗆 Yes	2/2/No 3□	Probably 4 Unknown
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nding Physith. Ith. : Atter this e funerel di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir	28a. Dat	Inpatient 2 e of Injury onth, Day Year)	28b. Time of Injury	28c. in	4 🗆 🖂			e 6 □Other (S injury occurred	Specify)
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ne Hospit 124 hour ne Funera letely filla	edical (ng Physician: To t Examiner: On the and ma								
To th withir To th comp	Me	29b. Signature and title of certifie	or .				ense number			Date signed (Me	onth, Day, Year)
		Ant	- 5/	ah Hire	mimo	\mathcal{D}_{i}	5164	3	9	77106	
8		30. Name and address of person		use of death (Item	n 23a) (Type,	Print)	516y.	/ ~ 5		77/06 1702	
Sta	ate	31. Date filed (Month, Day, Year)	2000	egistrar's Signa	ature LY	TIP	10001	7 / 1		1702	
Regist		MAI I	U ZUUb	Beller.	K B	males					

			For State Registrar	State of M	larylan	•	artmen rtificat			and M		giene Reg. No.	200	5	50	191
	Physicia /Medic	_	1. Decedent's Name (First, Middle, Jack Perlmutter	Last)							2. Date of De Month May	Day	2006	ar	ne of Dea	ath M
	Examin		4a. Facility Name (If not institution, Suburban Hospita)			Town, or thes	Location o	of Death		4c.	County of D Monte	eath comery		
	Funeral Director		5. Social Security Number 120-03-6136	6.Sex 7.A	ge (In yrs. 8	las <i>t birthd</i> ay) 6 Yrs.	If Under Months		If Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Jan. 23	, 192(9. I Ne	Birthplace (S Country) W Yorl		oreign
	Maryland febow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo	omery		y, Town or Lo Bethes									de City L	
	with the	I Direc	10e. Street and Number 9707 Old George	etown Road,	#220	1	10f. Zip	Code	2081	L4			zen of What ted St			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28e-f show emportent: If Item 27 is marked other then "natural", or Items 23a or 28e-f show all only only or other traumatic event, the Madical Examiner must be multified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Moving Widowed	12. Was Decedent Armed Forces ed 1 2 Yes 2 1 If Yes, Give Year or Dates:	? No		Was Decedif Yes, spe		spanic Ori n, Mexican Specify:	gin? (Spe 1, Puerto I	cify Yes or No Rican, etc.)		Black, W	merican India Inite, etc. White	an,	
Maryland 21215-0036	within 72 hou iene." then "natura the Wadical E	To Be Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	s Education t grade completed) College (1-4or	5+) 5+	16a. Dece (Give life. Art	kind of wo DO NOT u	rk done a	lurina mosi	t of workii	ng	16b. Kir	nd of Busine	ss/industry		
land	uld be filed Aental Hyg rked othe tic event,	ro Be C	17. Father's Name (First, Middle, I Morris	ast)		Perlm			18. Mothe Rebe		(First, Middle,	Maiden	Sumame)	Ka	atz	
Mary	alth and N		19a. fnformant's Name/Relationsh Gloria G. Cole			1	-				i Route Numbe esda, 1					
Baltimore,	Pages 1 and of Heiner ry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			tace of Disponentery, creations of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contrac					2006			or Town, Ste		ia
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Vita	Physician: The l this certificete har ral director, page	To Be	25. Was case referred to medical examiner? 1 Tyes 2 A.No	Hospital: 1 1 Inpat	tient 2	ER/Outpatie	nt 3 🗆 D0	Othe Othe	or.		ne 5□ Resi	77	S □Other (S	Бресіfу)		
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Divis	F 6 F C	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 200. Flace Ut II	njury - At he etc. (Specif	ome, farm, st	reet, factor	y, office		1	28f. Location (City or To			Rural Route	Number	τ,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical		g Physician: To the bes Examiner: On the basis and manner s	of examina										us e (s)	
)	-	Me	29b. Signature and title of certifier	Some	. N	D	29	c. License	onumber 00629	99	1		signed (M 5, 20	onth, Day, Yo 06	ear)	
	30		30. Name and address of person Petek Domnez, M.					d Re	theed	la M	arvl ond	200	1/4			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)		trar's Signa		and Road		CLIC3U	ici g l'h	ar A raile	. 200	14			

DHMH 17 Rev 1/2001

Jack Perlmutter may 4, 2006 43 4

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Dav 7, 2006 **Physician** 11:10 AM May PARKER GEORGE **EDWARD** TTT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Casey House Rockville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 2,1920 9. Birthplace (State or Foreign Country) North Carolina 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months 1**X** M 2□ F 86 237-24-1432 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b County r then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Director Montgomery Village Md. Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20886 United States 19120 Rhodes Way Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1∑ Yes 2 □ No 1940If Yes, Give Year or Dates: 1950 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Nuclear Engineer Nuclear Energy 5+ permit. Pages 1 and 2 should be filed w
Department of Heelth and Mental Hygier
Importeer; If Item 27 is marked other til
eny Injury or other traumatic event. In
one 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Edward Parker II Pearl Putnam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19120 Rhodes Way Montgomery Village, Md. 20886 Dorothy M. Parker (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 7, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 2006 Alexandria, Va. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee weter & 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Debility disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiomyopathy Sequentially list conditions, if a ry, leading to min solute cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ng physicien and as the burial-transit The law requires that the death certificate be executed Congestive Heart Failure that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending a IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4

☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown δ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2**X** No certificete 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as section.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and ti D35635 May 8, 2006 11+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd. Rockville, Md. 20855 Dr. Joseph Kaplan M.D. 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State 09 2008 Registrar

		1	For State Ragistrar	State of Ma	ryland / Dep <i>Ce</i>	artment of H artificate of I			giene 🛴 Reg. No.	000	ibU	94
	-		Decedent's Name (First, Middle, La	ast)				2. Date of Dea			3. Time of Dea	ath
	Physicia	an	DANGHANDDA		DALIAD			Month MAY 3, 20	Day DOG	Year	9:30	A^{M}
	/Medic	_	RAMCHANDRA 4a. Fecility Name (If not institution, gi		PAWAR	4b. City. Town, or	Location of Death	PIRT Je Z		nty of Death	7.30	
	Examin	er				SILVER SPI			MONT	GOMERY		
			11544 STEWART LANE, A		(In yrs. last birthday		If Under 24 Hrs.	8. Date of Birt	h		lace (State or Fo	reign
	Funeral			1 ⊠ M 2□F	65 Yrs.	Months Days	Hours Min.	(Month, Day OCTOBER 6		INDIA	ntry)	
	Director	-	Usual Residence of Decedent]	,			
	land m		10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City L	imits.
	Mary i eh	ō	MARYLAND MONTGOMER	v	SILVER SPR	TNG					1 Yes 2	No
	28e	Director	10e. Street and Number	1	5237211 5511	10f. Zip Code			10g. Citizen o	of What Cour	ntry?	
	Sa or	0	11544 STEWART LANE,	ΔPT Δ1		20904	+		U.S	S.A.		
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8	hours after death with the Maryland turei', or iteme 23a or 28e-f show at Ezantractinust te colilled at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specity:		Spe	city: ASIA	.N	
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ā	Aenta Aenta Treed tice	10	ABURAO BABAJE PAWAR				SHEVANTAB	AI	ABUR	CAS		
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Σ	aith a		SHARDA DIGHE/DAUGHTE	R	11544	STEWART LA	NE, APT. Al	, SILVER	SPRING,	MARYLAN	D 20904	
ē	H to the		20a. Method of Disposition		20b. Place of Disp cemetery, cr	position (Name of ematory or other place	ce)	Date	20c. Locatio	n - City or To	own, State	
Ë	Pege ent c nt: #		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			LN CREMATOR		/2006	BRENTWOO	D, MARY	LAND	
altimore,	mit.		21. Signature of Funeral Service Lice	ensee		22. Name and Addre	ss of Facility	OME THE				
Ö	permit. Peges 1 end 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other treumatic es one.		1 (Imanda	Ludeur		IINES-RINALD 1800 NEW HAI	I FUNERAL H MPSHIRE AVE	NUE, SILV	ER SPRIN	IG, MARY	LAND 2090	14
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	inplications that caused	the death. Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between	an
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	/Medical		disease or condition resulting in death)	a. ARRHYTHMIA	a consequence of):							
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Box	death certifi e attending ed for use as	Ş	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth		B⊟Ectopic pregnanc	,			Date of deliv		.,
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Œ	The I	E						perfo	rmed?	death? 1 ☐ Yes		
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>	Physician: this certific ral director,	To B	examiner? 1 XYes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpat	ent 3□ DOA Ott	ner: 4 🗌 Nursing H	ome 5 🔀 Resi	dence 6 🗆	Other (Specia	fy)	
υot	- he		27. Manner of Death	28a. Date of Injur (Month, Da)	y 28b. Time (Year) Injury		ry at rk?	28d. Describe	how injury oc	curred		
0	Attending r death.	atic	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	ion			Yes 2 □No					
Division	er de	#	3 Suicide 6 Could not 4 Homicide determine	28e. Place of Inju- building, etc	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (City or To		imber or Rur.	al Route Number	r,
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	To the h within 24 To the F complete	Med	one)	and manner sta	ited.	29c, Licens	se number		29d. Date sig	ned (Month	Day, Year)	
	5 ¥ 5 00	-	29b. Signature and title of certifier	10000001		250. LIOSTI			_00. Date 310	5.100 (MORILI),		
	1		1 100	WILLIAM TO THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PAR		D4257	8		MAY 6, 2	2006		
			30. Name and address of person wh				UTITE 1417	T AND COC	2			
			GUL CHABLANI, M.D.,	11119 ROCKVIL	LE PIKE, STI	E. 4UL, KUCK	VILLE, MARY	LAND 2085				
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registra	MARY S	LA STORY						
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State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Physician MAY 6, 2006 Rivera Louise 0618 a /Medical 4c. County of Death 4b City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Leonardtown St. Mary's Hospital 8. Date of Birth (Month, Day, Ye May 19, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 🖔 F 96 Yrs. 1909 Washington, DC 579-40-6178 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 28a-f ahow permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f ahow an injury applier traumatic event, the Madical Examinar must be natified and note. 1X Yes 2 No Maryland North Beach Calvert Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20714 U.S.A. 854 Bayfront Ave. PO Box 597 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc I □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ White 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Buscher Antoniette McLoughlin 19b. Mailing Address (Street and Number or Aural Acute Number, City or Town, State, Zip Code) 854 Bayfront Ave. PO Box 597 North Beach, Maryland 20714 19a. Informant's Name/Relationship (Type, Print) Elizabeth Corona/Daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition or other place) Gate of Heaven Cemetery May 11, Silver Spring, Maryland 1X Burial 2 □ Cremation 3 □ Removal from State 2006 4 ☐ Donation 5 ☐ Other (Specify) DeVol Funeral Home 21. Signature of Funeral Service Lice see 22. Name and Address of Facility 2222 Wisconsin CAve 20007.W. Washington, D.C. 20007 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) disease Louonam **Physician** /Medical Due to (or as a consequence of): **Examiner** enternon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) RIVERIA O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 X No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? E LOUISE | Records, F Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 X No 1 Yes MARII Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60888 106. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25500 Point Lookout Rd. Leonardtown, MD 20653 Suresh H. Patel, M.D. 32. Segistrar's Signature 31. Date filed (Month, Day, Year) State MAY 09 2006

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Registrar

Deci D.C

State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Month MAY 8, 27006 03:11PM Anna Mae Rowe /Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4a. Fasily Name (" not institution pive Meet and number" Center Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 X F 65 Yrs. Director 215-36-5962 Oct.18,1940 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. fnside City Limits 10b. Count rs!, or items 23s or 28e-f show Examiner must be notified at 1 ☐ Yes 2 X No Directo Washington Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Pages 1 end 2 should be filed within 72 hours after death v Department of Heelth and Mental Hygiene Importent: If itsm 27 is marked other than "naturat", or Itams 23s eny injury or other treumatic event, the Medical Examiner must place. 11208D Pepperbush Circle 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (5)No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XW Specify δ 3 ☐ Widowed 4 Divorced White Completed 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Efementary/Secondary (0-12) Colfege (1-4or 5+) 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Franklin Sarah Rowe May Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Leggett - Daughter 19 E. Sunset Avenue Williamsport, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park May 12,2006 Williamsport, Maryland 21. Signature of Fureral Service Lica Osborne Funeral Home, P.A. 425 S. Conococheague St. Williamsport, Maryland 23a. Part I. Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between DAYS Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL ISCHEMIA Physician /Medical CURONARY ARTERY DISEASE Examiner YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Completed by Physician/Medical attending for use es 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetaf death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 200 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an certificate has b lirector, page 2 s 2 No 1 Yes 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: Inpatient 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manper of Death

1 Natural

2 | Accident

3 | Suicide

4 | Homicide

29a. Certifier

(Check only one)

29b. Signature and title of certifier After thi 28b. Time of Injury 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Twithin 24 hours effer d Hed in by Certifying Physician: To the best of my knowledge, death underred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) D57593 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 21204 SANG NA M.D. 7601 31. Date filed (Month, Day, Year) 32. Refistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#5, perInf, C358, 8/2/06 TT

1- For Amend Item 1 per Dr., C356, 06/2/06dhb

Registrar

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Rodeheaver May 11, **Physician** Ruby Valetta Rodeheaver 2006 Ruby Valetta 4:18 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett County Memorial Hospital 0akland Garrett 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year) 1/29/1910 Birthplace (State or Foreign Country)
 WV Social Security Number **Funeral** 234-64-1343-54 1 ☐ M 27 F 96 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examilied 1. ust be notified 1. once. 1 ☐Yes 2√2 No Director Preston Mountain Dale 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? RR 3 Box 234 26525 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽŽ No White Specify: 2 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel Wilbert Livengood Maude A. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert F. Rodeheaver/Son 429 North 2nd Street, Oakland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Spt 525 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Shady Grove Cemetery 5/14/2006 Bruceton Mills, WV * 4 ☐ Donation 5 ☐ Other (Specify) Funera ervice censee 21. Signature 22 Name and Address of Facility Funeral Home 5 Box 1, Bruceton Mills, 23a. Parti. Enter the disease, or complications shock, or heart failure. List only one caus hat caused the death. Do not enter the mode of dying, such as pardiac or respi Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of Examiner ed by the attending physician and detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ certificate has been sign rector, page 2 should be 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 22 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 📉 🐪 2 ER/Outpatient 3 DOA this. 27. Manner of Death 28b. Time of 28d. Describe how injury occurred I or Attending P safter death. I Director: After Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral D 1 Certifying Physician: Te the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 11, 2006 ms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert A. Goralski, M.D., 311 N. Fourth Street, Oakland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 12 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1- State Registrar Amend # 24a per/phys 05-10-2006tificate of Death CNM 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death May Month 2006 **Physician** NANCY LEE SMITH P M 4:10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Homewood at Crumland Farms Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** Days 1 □ M 2 ₩ F 70 1936 212-38-7771 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 17 is marked othar then "natural", or Items 23a or 28e-f show traumatic event, the Medical Examinar must be notified at 1∏Yes 2□No Director Maryland Frederick Frederick 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 7407 Willow Road 21701 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Vas Giva Specify: þ 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If itam 27 is marked other then "n any injury or other traumatic event. It Much app. pings. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Patrick Lamar Moore, Sr. Mary Wiggington ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan L. Baugher / Daughter 8608 Wiles Court, Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 5/11/06 * 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Lice COBERT E. DAILEY & SON FUNERAL HOMES, P.A. 23a. Part1. Seter the disease or complications that daysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximately a set of the disease of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the dea Approximate Interval Between Onset and Death Obstructive Almorary Disense Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ornowing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): the attending physician hed for use as the buria Box 68760 Physician/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 140
9 Unknown Day 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 12 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy enforme 1 ☐ Yes 2 ☐ No 2 XNo Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attanding I 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D16428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cline, III, MD 300 West 9th Street, Frederick, MD 21701 Casper E. 31. Date filed (Mathamy, Tar) 2006 legistrar's Signature State Registrar

DHMH 17 Rev 1/2001

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06-03204 Veronica L. See Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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Physician	7	Decedent's Name (First, M	iddle,Last))							Date of Death Month	Day Year		3. Time of Death
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	ľ	4a. Facility Name (if not insti Frederick Memoria						Town, or lerick	Location of	f Death		4c. County o		
·		5. Social Security Number	6. Se		(In use I	ast birthday)		der 1 Yea	r If Under	r 24Ure To	Date of Righ	(MM/DD/YYYY)		hplace (State or
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any		Usual Residence of Deceder 10a. State 10b. Cou		_	10c. City,	Town or Lo	cation				- <u></u>			10d Inside City Limits
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arylar 88a-f s	3 F	10e. Street and Number						ip Code			100	g. Citizen of Wha	at Coun	try?
ith the Maryland 23a or 28a-f sho notified at once	2 -	8 Center St	reet	12. Was Decedent	Ever in II	9 13 1	Mas Deced		1716	in? / Specit	y Yes or No-	United		can Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		1 Never Married 2	_	Armed Forces?	X No		f Yes, spec	cify Cubar	n, Mexican,			White	etc.	
ural",	⋧┞	3 Widowed 4 X 15. Decedent's Education (If Yes, Give Year or Dates: ly highest grade com	nleted)	16a Dece	dent's Usua		specify:	and of work	done	Specify: 16b. Kind of Bus		hite
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan	ᇍᅡ	Elementary/Secondary (0-		College (1-4 or 5			most of wo					TOD. TAING OF BUC	111000711	idddi y
thin 7 than 7 than than	1	12				н	lomema	ker				Own	Hon	ne
5-00 ed wi Hygier other Ithe M	3	17. Father's Name (First, Mic	dle, Last)					T	18.Mother's	s Name (Fi	rst, Middle, Ma	aiden Surname)		
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygene. n 27 is marked other than wumariic event, the Medica		Richard Se									Scrape			
should and Me is ma artic ev		19a. Informant's Name/Relat		,								er, City or Town		
md 2 salth a		Miranda Rich 20a. Method of Disposition	/ Dau	gnter	20b	Place of Disp	_					ass, Ore	_	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours afte men of Health and Mental Hygiene faut: If item 27 is marked other than "natural" or other traumatic event, the Medical Examine To Bo Compulated by		1 Burial 2 X Crema	ation 3	Removal from Sta		crematory or			,,,,,,,		16.		,	,
Baltimore, permit. Pages I ar Department of He, Important: If ite	1	4 Donation 5 Othe 21. Sgnature vuneral en		200 4	Fr	ederic	k Cre	emato	ry	May 20				Maryland
			2	100		1	100 N	I. Ma	ple A	venue	Brun		Mary	land 21716
Physician /Medical		23a. Part I. Enter the disease failure. List only one ca	use on each	ch line.			er the mode	e ot ayıng	, such as ca	ardiac or re	spiratory arres	st, shock, or hea	1	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final dise or condition resulting in deat	ase a. h) r	Hypoxic en			ZO 2m -	intov	ication	n			_	Death
	-	Sequentially list conditions,	b.	Mixed Dru	g (Al	prazola	n) into	exicat	ion.	ň				
red nisit		if any, leading to immediate cause. Enter Underlying Ca (Disease or injury that initiat	use	Due to (or as a conse	equence o	of):								
760, from the executed grants and the burial - transit		events resulting in death) L	ast C	Due to (or as a conse										
760, cate be evecuted physician and the burial - transi	8	X UNPENDED	X	AMENDED ite	m#23a-	-b,27,2	Ba-f,pe	erME,(856,6/	30/06	ŢΤ			
760, ficate be g physical the burn	- 1	IF FEMALE: 23b. Was decedent pregnant	in the	23c. If yes, outcom	ne of preg	nancy				//U0-11		23d. Date of o		
Box 687 e death certifit the attending ed for use as t	Pnysician	past 12 months?		1 Live birth 4 Pregnant at	time of de	eath 5	Other (Sp.		Ectopic	pregnancy		Month	D	ay Year
Box death he atte d for t		1 Yes 2 No 9	Unknown			3 🗌	Other (Op	ecity)						
P.O. B res that the d signed by the be detached		Part II. Other significant co	nditions	contributing to death	but not r	esulting in th	e underlyin	ng cause	given in Par	rt I.	23e. Did tob	acco use contrib	ute to t	he cause of death?
ires the signed able do	a by										1 Yes	2 ✓ No 3	Proba	ably 4 Unknown
ords v requi	Completed										24a. Was ar autops			opsy findings available ompletion of cause of
he law ate has age 2 sh	Ē	-									perform 1 Yes 2		eath? ✔ Yes	s 2 No
tal Rection: The certificate ector, page		25. Was case referred to me						26.Plac	e of Death ((Check only	one)			
Vita hysici this c	0	examiner? 1 ✓ Yes 2 No	Н	lospital: 1 🗸 Inpatie	nt 2	ER/Outpati	ent 3	DOA	Other ₄	Nursing H	ome 5 R	esidence 6	Other	
ing Physician: The law requiring Physician: The law requiring After this certificate has been funeral director, page 2 should		27. Manner of Death		28a. Date of Inju (Month, Day,Y		28b. Time	of Injury	1	ry at Work	- 1	d. Describe ho	w injury occurre	d	
ttend death rtor: y the i	<u>ا ڇ</u>	5	Pending nvestigation			Fnd 11			Yes 2		known			
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death. After this certificate has been signed by filled in by the funeral director, page 2 should be detach.	ertification:		Could not be					ry, office	building, etc	c. 28t	f. Location (St or Town, Sta	reet and Numbe ate & Cente	r or Run	al Route Number, City
Dospita hours meral	ا د	4 Homicide		(Opeany) 10	-									
Division of Vital Records, P.O. Box 68 within 24 house after death or iff or the Hospital or Attending Physician: The law requires that the death certify of the Funeral Directors. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as considered.	edica	(Check only one) 2 Medical	Examiner	an: To the best of m On the basis of exa- and manner stated		_	igation, in n	ny opinio	n, death occ		e time, date ai	nd place, and du	e to the	e cause(s)
	Ξ	29b. Signature and title of ce	rtifier	///			29		se number			29d. Date signe		th, Day, Year)
		XIVV	V					O.C.	.M.E.			May 15, 200	16	
0	ſ	 Name and address of pe Susan Hogan MD. 		completed cause of constant Medical Ex			enn Stre	et Ral	timore N	MD 2120	1			
Stat	te.	31. Date filed (Mon May)			r's Signat		J J. 10	, Dai	ore, IV	2120				
Registra		m _M 1	1 8 2	2006 32. Redistra	معد		base							

			For State Registrar		State of I	Maryland	-	irtment (tificate			and M		Reg. No.	2000	16100
	Physici	an	1. Decedent's Name (2. Date of Do Month	Day		3. Time of Death 11:05 A M
	/Medio		4a. Fecility Name (If n		reet and number	9r)		4b. City, To	wn, or l	Location o	of Death	May		2006 County of De	
O Company	LAdilli		C.J. Ass	sisted Liv	rine			Hager	sto	wn			Wa	ashing	ton
100	Funeral		5. Social Security Nun 579-10-56	nber 6. Sex		Age (In yrs. la	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bi (Month, D	ay, Year)		Birthplace (State or Foreign Country)
	Director		Usual Residence of D			07	113.					May 28	1918	3We	st Virginia
	how			10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	8a-f	ctol		Washingto	n		Hager								XXYes 2□No
	with the	Funeral Director	10e. Street and Numb					10f. Zip Co					-	zen of What	•
	ms 23	era	11. Marital Status		2. Was Decede Armed Force	nt Ever in U.S	S. 13. \			panic Orig	gin? (Spe	ectfy Yes or N Rican, etc.)			merican Indian,
9	or Ite	Fur	1 Never Married	d 2□ Married	Amed Force 1 ☐ Yes 2 If Yes, Give	e? ∑No		Yes, specify		Specify:	, Puerto	Hican, etc.)	ì	Black, W Specify:	
21215-0036	72 hours after death with the Maryland Insturat; or Items 23s or 28s-f show dical Examinat must be notiling at	d by	3 AWidowed 4		Year or Date	s:									White
-5	in 72 n "nat fedic	Completed	(Specify	5. Decedent's Educ only highest grade	completed)		(Give	lent's Usual (kind of work of DO NOT use :	done du retired)	uring most	t of work	ing	IBD. AII	nd of Busine:	ss/industry
212	d within giene.	mo	Elementary/Second	any (0-12)	College (1-4d	or 5+)	Admir	istra	tive	. Ass	ista	nt	U.S.	Gover	rnment
	be filed tal Hygie d other	Be	17. Father's Name (F	irst, Middle, Last)								First, Middle		,	
<u>y</u> a	should be fand Mental Harmanked of	٥	John Edwa		on Orinti		10b Mallia	a Address (6				ssell			. Zin Cadal
Maryland	d 2 st th and th s n traun	1		sselring				-				n, MD 2	-	r Iown, State	a, 21p Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f ahow many injury or other traumatic avent, the Medical Examinal must be notified at once.		20a. Method of Dispo	sition		CO	ace of Dispo	sition (Name	of	1		Date		cation - City	or Town, State
E C	Pages nent of int: If it			Cremation 3 □Re	moval from Sta	IIO	k1awn	-		Mε	ay 10	2006	Rock	ville,	MD
Baltimore,	permit. Departn Imports any inju		21. Signature of Fore	eral Service License	9		22	. Name and	Address	of Facilit	у Јо	seph Ga	wler	's Sor	s Inc.
ш	405 a a		23a. Part 1. Enter the	The Willes	19	and the death								ton DO	20016
	Physician		shock, or heart Immediate Cause (Fi disease or condition	failure. List only on	Atlan	osclero	523	ar the mode t	n dying	, such as	Cardiac	or respiratory a	irest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		Due to (or	as a consequ	ence of):								
	pe	Examiner	Sequentially list conditions, leading to in a cause. Enter Underly Cause (Disease or in	ditions, b.	©ua to (cr	as a consecu	ianda of):								
ó	ate be executed thysician and the burial-transit		that initiated events resulting in death) La	■ C.	Due to (or	as a consequ	ence of):								1
8760,	ate be hysicia ihe bu	licai		d.											
9	teath certifica attending ph d for use as the	Physician/Med	IF FEMALE:	25	Sc. If yes, outcor	me of pregnar	201/								
Вох	attene attene	cian	23b. Was decedent p in the past 12 m 1 \(\sum \text{Yes} 2 \(\mathbb{K}\)	onths?	1 Live birth	2 Fetal t at time of de	death 3[Ectopic preg Other (spec					2	3d. Date of one Month	Day Year
Ö.	t the d by the tachec	hysi	9 Unknown	NO	9□ Unknown	ר			,,						
rds, P	w requires that the de been signed by the a should be detached t	þ	Part II. Other signific	ant conditions con	tributing to deat	h but not resu	Iting in the ur	nderlying cau	se givei	n in Part I.			tobacco u		to the cause of death? Probably 4 Donknown
Records,	E 28	Completed										24a. Was auto perf 1 \(\subseteq Yes	psy ormed?	24b. Were prior t death 1 \(\supers	
Vital		Bec	25. Was case referre examiner?	/						26. Place	of Death	Check only			
of V	Physician: this certific ral director,	မ	1 Yes 2 N	o H	ospital: 1 🔲 Inp		ER/Outpatien		Other	4 🗀 190	rsing Ho			Other (S)	овсту)
ono	ding h	tlon	1 Natural	5 Pending investigation	28a. Date of I (Month,	Day Year)	28b. Time of Injury	M 280	. Injury Work′ 1 □ Y	at ? es 2 □ I		28d. Describe	now injury	/ occurred	
Division	Attending r death. ector: After by the fune	ifica	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	28e. Place of	Injury - At hor	me, farm, str					28f. Location	Street and	d Number or	Rural Route Number,
ā	tal or	Certification;	4 _ Homicide	,	bullaing,	, etc. (Specify,	/					City or 10	wn, State)		
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 (Check only 2 one)	Certifying Phys	ician: To the be er: On the basis and manner	s of examinati	vledge, death ion and/or in:	occurred at restigation, in	the time my opi	e, date an inion, deal	d place, th occurr	and due to the ed at the time	cause(s) date and	and manner place, and d	as stated. ue to the cause(s)
	To th To th comp	Me	29b. Signature and ti	tle of certifier		. 3		1		number					nth, Day, Year)
	12	17	· M	Hur	A		uns		005	6783			May	8 200	6
	100	14	Jeffret H	rwitz MD	Heter cause 111110		23a) (Туре, са 1 Сат		130	Наос	reta	own, MD	217/	4.2	
3	Sta		31. Date filed (Month	, Day, Year)		strar's Signat		book	•			wird LID	-1/-	T 4	
	Regist	rar	7	MAY 09	LUUU D		1								

			For Stete Registrer	State of Ma	aryland /		artmen tificate			and M		iene	06	151	01
			Decedent's Name (First, Middle, Las	t)							2. Date of Deat Month		Year	3. Time of I	Death
	Physicia /Medic		ELWOOD H. SILVER	STONE							MAY 4,		Tear	3:30	РМ
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of	of Death		4c. Coun	ty of Death		
			HOLY CROSS HOSPI						SPR				10NTGO		
T	Funeral		Social Security Number 6. Security Number	ox 7. Age ⊠M 2□F	e (In yrs. last I	birthday) Yrs.	If Under Months	Days	ff Under: Hours	Min.	8. Date of Birth (Month, Day)	, Year)		place (State or ntry)	
	Director		578-22-2218 Usuaf Residence of Decedent		81	113.					JAN 6,	1925	WASHI	NGTON,	D.C.
	land ow		10a. State 10b. County		10c. City, To	wn or Lo	cation						1	0d. Inside Cit	y Limits
	r 28a-f show	ţ	MARYLAND MONTG	OMERY			5	SILVE	R SPI	RING				1 ☐XYes	2 🗆 No
	death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen o	f What Cour	ntry?	
	23a c	ain	11613 FULHAM STRE	ET					2090				S.A.		
	r dea	nue	11. Marital Status	12. Was Decedent I Armed Forces?		13.	Nas Deced f Yes, spec	dent of His cify Cubar	spanic Ori n, Mexican	gin? (Spo 1, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ ack, White,		
9	hours after tural', or Ite	by Fi	1 ☐ Never Married 2 ☐ Married ☐ 3 ☒ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	No TITT		1 🗆 Yes	2 √ №	Specify:			Spec	ify: WHI	TE	
2-0036	hin 72 hours after death with e. an "naturel", or Items 23a oi Medical Examir er must be		15. Decedent's Ed			Sa. Deced	dent's Usua	al Occupa	tion			16b. Kind of	Business/In	dustry	
<u></u>	within 72 ene. then "nat	plet	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5	54)	(Give life. i	kind of wo DO NOT us	rk done di se retired)	uring mos	t of work	ing				
77	¥ € ₩ #	Completed	Clementary/Secondary (5 12)	5+	,,,		D.D.S	5.					DENT	CISTRY	
פ	al Hygid al Other vent, I	Be C	17. Father's Name (First, Middle, Last)								e (First, Middle, i	Maiden Suma	ame)		
yland	Ment Ment arke	2	JOSEPH SILVERSTON	E							FFMAN				
Mar	2 shd and Is m		19a. Informant's Name/Relationship (7		1:		3				al Route Number				2
	and Health Im 27 Iher t		ELIOT R. SILVERST 20a. Method of Disposition	ONE/SON	20b. Place				DKT		ROCKVILI Date	LE, MAI 20c. Location			3
Baltimore,	Pages in ment of the mit: If its		13亿 Burial 2 ☐ Cremation 3 ☐		ceme	tery, crer	natory or o	ther place			/2006	OLNEY			
	Para Far		4 □Donation 5 □ Other (Specify 21. Signal up of Fugurar Service Licen		JODEA		. Name an				7 2000	OBNET	, FIAICI	LIMI	
Ra	permit. Pages 1 and 2 should Department of Health and Me Important: If Itsm 27 Is mark any injury or other traumetic		PATE D	300		DA	NZANS	SKY-G	OLDB	ÈRG :	MEMORIAI , ROCKVI	CHAPI	ELS, I	NC.	852
			23a. Parl 1. Enter the disease, or comp	olications that caused	d the death. D	o not ent	er the mod	e of dying	, such as	cardiac o	or respiratory arr	est,	TAKILA	Approximate finterval Betw)
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each III	ne.	1	ny	00	(مرجو	IR	Pin	Fana	~	Onset and D	
	/Medical		disease or condition resulting in death)	Due to (or as	a consequence	ce of):	1	VC		1 0-	-	1-47	Am	-	
ı	Examiner		Sequentially list conditions	b											
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as	a consequence	ce of):									
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequenc	ce of):									
760,	ate be executed hysician and he burial-transit	calE			,	,									
687	ficate physis the	_		d											
Box	death certificat e attending phy d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. ff yes, outcome 1 ☐ Live birth			Ectopic pi					23d. E	ate of delive		
	0 0 0	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at			Other (sp					K	Aonth	Day Y	'ear
<u>о</u>	at the de by the a	hys	9 Unknown					_			00 Pills	- 1	granico		
Ś	The law requires that the ste has been signed by th bage 2 should be detache	by	Part fl. Other significant conditions of	ontributing to death b	out not resulting	g in the u	ndertying d	ause give	n in Part i			es 2 □No		he cause of de pably 4 🖭	
9	w requir	eted								-					
Records,	hash hash ge 2 s	Completed						-			24a. Was a autops perfor	sy med?	prior to co death?	psy findings a mpfetion of ca	use of
			25. Was case referred to medical		- · · · - ·				OC Disease	of Door		2 No	1 🗆 Yes	2E No	
Vita	ysician: is certific director,	To Be	examiner?	Hospital:	ent 2□ER/	Outnatier	nt 3 🗆 DO	Othe	00		h <i>(Check only or</i> me 5 ☐ Resid		ther (Specif	(v)	
ō	두드		27. Manner of Teath	28a. Date of Inju (Month, Da	ıry 28t	b. Time o		28c. Injury Work			28d. Describe h		- · · · ·	,,	
<u>0</u>	ath. r: After he funer	atio	1atural 5 Pending 2 Accidentinvestigation	1	y reary	піјагу	М		res 2 🗌	No					
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of in	jury - At home, tc. (Specify)	, farm, sti	reet, factor	y, office	_		28f. Location (S City or Town		n <i>ber or Rura</i>	al Route Numi	ber,
0	urs at urs at ural D	Ce		3											
	To the Hospital or Attentwithin 24 hours after deatl To the Funsral Director: completely tilled in by the	edical		ysicien: To the best niner: On the basis o and manner st	of examination										
	To the within 2. To the Complet	Me	29b. Signature and title of certifier				29	c. License	number		2	9d. Date sign	ned (Month,	Day, Year)	
	7.1		1)00	Prids	1		1	DU	-52	+7	-)	5	141	06	
	00		30. Name and address of person who	completed cause of c	death (Item 23	а) (Туре,	Print) 1.	500 I	FORES	T) GL	EN ROAD	, SILVI	ER SPR	RING, M	D
			Yeneyis	Negu	SSIR	M	7. D			101	TOM	2,3	H18	77.20	310
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2006 3y. Registr	rar's Signature	1 6	borde	,			,		6		
	3			1000		-/									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () § Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 2006 Month **Physician** Alan Marc Shapiro 1, 10:00P May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Casey House Hospice Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 11 (Month. Days Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**½** M 2□ F 47 577-66-8119 Director Washington, DC Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location if item 27 is marked other than "natural", or Items 23e or 28s-f ehow or other treumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 14 Yes 2 □ No Director Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 U.S.A. 11208 Lombardy Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Peges 1 and 2 should be filled within 72 hours after of Department of Health and Mental Hygiene. If item 27 is marked other than "naturel", or Ite t Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 2 . 5 Elementary/Secondary (0-12) never worked never worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maxine Sandra Gibbons Shapiro Ehrlich Barton M. Shapiro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12415 Kemp Mill Rd. Slver Spring, MD 20902 Barton M. Shapiro/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) King David Mem.Garden 5-5-06 Falls Church, VA eny injury 22. Danzansky Goldberg Memorial Chapels, Inc. 21. Signature of Funeral Service Licenses 1170 Rocikville Pike Rockville, MD 20852 onold (Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Liver Cirrhosis **Physician** /Medical Due to (or as a consequence of): Examiner Hepatitis C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physicien and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 2 🖾 No 1 Yes 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ₺ Other (Specify) Hospice Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funerel Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and 29d. Date signed (Month, Day, Year) May 3, 2006 D35635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan 18111 Prince Philip Drive Olney, MD 20815 31. Date filed (Month, Day, Year) MAY 0 32. Aegistrar's Signature State 9 Registrar

			For State Registrar	State o	f Marylan			t of He			Reg	_ 4	006	16103
	Physicia		1. Decedent's Name (First, Middle, Last, Ruth Ehrlich S		er					2. Da	ite of Death onth	Day,	2006	3. Time of Death 10:00p M
	/Medic Examin		4a. Fecility Name (If not institution, give 8014 Aberdeen		mber)			Town, or	Location of Dea				tgome	~
1. E	Funeral Director		004 10 0020	м 2 Д F	7. Age (In yrs.	last birthday) 83 Yrs.	If Unde Months		Hours Mi	n. 8. Da (M OC	te of Birth onth, Day, Y t . 18,	1922	9. Birthp Coun Ge	lace (State or Foreign try) rmany
	filed within 72 hours after death with the Maryland Hygiene. ther than "naturelt, or liams 23e or 28e-1 show ont, the Modical Exercites must be notified at	ai Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome 10e. Street and Number 8014 Aberdeen Road	•		y, Town or Lo	.a. 10f. Zi	o Code 20814				. Citizen of	What Coun	
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Maryland	0 7 5	To Be	17. Father's Name (First, Middle, Last) Walter F. Ehr	lich					18. Mother's N Her		te Fle		718) 	
Baltimore, Mary	permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ance.		19a. Informant's Name/Relationship (T) Eric M. Schneider 20a. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify	- Son	State 20b. F		Monr esition (Na matory or	ne St		# 102 Date	, Rock	ville c. Location	, Md.	20850
Baltil	permit. P Departme Importan any injur		21. Signature of Funeral Service Licens	000	##	2 H	Name a Ldwa'r	nd Addres d Sag	sel Fun	eral	Direct	ion,	Inc.	
9	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aDue to	each line. theroscl	Lerotic	Car	diova	scular	Dise	ase			Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate auss. Fine Incertying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseq									
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregni birth 2 Feta pnant at time of c nown	il death 3	⊒Ectopic ⊒ Other (s	pregnancy					ate of delive	ary Day Year
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al Records,	: The law require cate has been si , page 2 should l	Completed								1	4a. Was an autopsy performe Yes 2	24b.	Were auto prior to co- death? 1 \(\text{Yes} \)	psy findings available mpletion of cause of
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	10		30. Name and address of reson who of Dr. Irving Miz	us 102	use of death (Ite	m 23a) (Type wood R	Print)			esda	Mary	land	20817	7
*0	St Regist	ate rar	31. Date filed (Month, Day, Year)		Registrar's Sign		ande							

		1	For State Registrar	Stat	e of M	1 arylan	nd / Depa			ealth a		lental Hy	giene Reg. No.	2001	5 15101	1
		_	. Decedent's Name (First, Middle,	Last)								2. Date of De			3. Time of Death	
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Exan	niner	4	a. Facility Name (If not institution,	,			1.40	4b. City	Town, or	Location	of Death		4c.	County of Dea		
		5	\$ /V///	6. Sex	ILAIC.		last birthday)	If Unde	ى ك r 1 Year	If Under	20 Hrs.	8. Date of Bi	rth		thplace (State or Foreign	_
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how			0a. State 10b. County			10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 No	
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of Herrican		2	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 DRamous	from Stat	/	Place of Dispo	sition (Na	me of other plac	e)	[Date	20c. Lo	cation - City o	Town, State	
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permit. Pages 1 an Department of Heal Important: if Item 2 ony injury or other	once.	:	21. Signature of Fugeral Service L	icensee									_	ıneral	Home	1
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Phys grattys	F		27. Manner of Death	28a.	Date of In (Month, D		ER/Outpatier 28b. Time of		28c. Injun	/ at		me 5 ⊔ Hes 28d. Describe		Other (Specy occurred	ocity)	-
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			30. Name and address of person	who complete	cause of	f death (Ite	m 23a) (Type,	Print)	× 76	554				148,2	000	-
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2006 3:42p May 10 Hilda M. Sexton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Marydel Caroline 18531 Crownstone Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. (Month, Day, Year) May 31 1926 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 ☐ M 2 💢 F 85 1920 New York Director 062-14-0941 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State r than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Caroline Marydel Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21649 18531 Crownstone Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ White 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygiens important: if itam 27 is marked other tha any njury or other traumatic event. The 2016. head of housekeeping hotel business 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nora Kelly Burns Lawrence Burns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PO Box 82 Round Top, New York 12473 Joseph Burns/ brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 05/20/2006 Ft. Lauderdale, FL Queen of Heaven Cm 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home, PA
PO Box 160 Greensboro, Maryland 21639 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final mas Frysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month ģ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. by 1 | Yes 2 | Probably 4 | Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy page 2 No 1 Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 200No 1 🗌 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? or Attanding 5 Pending 1 Yes 2 No s after death. 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and D35284 5/11/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Washington St Easton mo 260/ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of I	Marylan	nd / Depa		t of H	ealth a		lental Hygi		006	16106
	Physici /Medic		1. Decedent's Name (First, Middle Richard	Willing		Schu					2. Date of Death Month May	Day 11, 2006	Year	3. Time of Death 9:00 A. M
	Examin Funeral Director	er	4a. Facility Name (If not institution 5. Social Security Number 220-26-6628	Moran Mano	or	last birthday) Yrs.	4b. City, If Under Months		We If Under:	estern	port 8. Date of Birth (Month, Day, December 2	Year)	9. Birthe	gany olace (State or Foreign of Columbia
199	D	tor	Usual Residence of Decedent 10a. State 10b. County	Allegany		ty, Town or Lo	cation	V	/estern	port	December 2	9, 1930		Od. Inside City Limits
	ath with the 23a or 28 und be not	ral Director	10e. Street and Number	01 Shady Lane			10f. Zip		21562			g. Citizen of	What Cour	-
960	a within 72 hours after death with the Maryland liene. rthan "natural", or Items 23s or 28s-f show It o Medical Examination must be notified at	by Funeral	11. Marital Status 1 🗷 Never Married 2 🗆 Mari 3 🗆 Widowed 4 🗀 Divorced	If Yes Give	es? ∐No		Vas Deced Yes, spec	-	spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		ice - Americ ack, White,	
Maryland 21215-0036	71 25 2 2	Completed		t's Education st grade completed) College (1-4e)	or 5+)	16a. Deced (Give life. I	lent's Usua kind of wor DO NOT us	rk doné d se retired,	uring most		ng	6b. Kind of E	Business/Ind Plumb	
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	and 2 should halth and Mer n 27 is marke er traumatic		19a. Informant's Name/Relations Dorrie Winega	rdner - Daughter				2808	Spiral		N Route Number, Bowie, Ma	·		Code)
Baltimore,	mit. Pages 1 an octment of Heal octment: If item 2 injury or other is.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S	Specify)		Place of Dispo cemetery, cren The Cumb	erland	Crem	atory		May 12, 2006		erland,	Maryland
Bal	permit Deper Impor any in		21. Signature of Funeral Service S. M. 23a. Part1. Enter the disease, or	Kezi						Lona	uneral Hom coning,Md.	21539	B East M	fain St.,
68760,	Physician /Medical Examiner and physicien and sthe pnujar-transit sthe pnujar-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a c	juence of):	Al.	zhe	mer	S	Deme	AT A		Interval Between Onset and Death
P.O. Box 6	death certif e attending od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □Live birth 4 □ Pregnan 9 □ Unknowr	t 2 ∏ Feta tat time of d	ıl death 3□	Ectopic pre					ì	ate of delive	ory Day Year
	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and the Coron and th	ons contributing to death	h but not res	sulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did toba		stribute to th	ne cause of death?
tal Rec	The law ste has b	e Completed	Ohs trucker Linerker 25. Was cas re- rred to medica	sian	ulr	novan	7 (ns	26 Pieses	of Dooth	24a. Was an autopsy perform 1 Yes 2	ed?	prior to cor death?	psy findings available npletion of cause of
of Vi	hys this	To B	examiner 1 Yes 2	Hospital:		ER/Outpatien			r. 4 35 Vui	rsing Hor	me 5 🗆 Resider	ice 6 □Otl		1)
Division of Vital Records,	r Atter ter dea irector	Certification;	27. Manner of Death 1 Neural 5 Pendir 2 Accident investi 3 Suicide 6 Could 4 Homicide	ng (Month, gation not be 28e. Place of	Day Year)	28b. Time of Injury ome, farm, stra (y)	М			No	28d. Describe how 28f. Location (Stre City or Town,	et and Numi		l Route Number,
Ω	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical Ce	29a. Certifier (Check only one) Medical	Physician: To the be Examiner: On the basis and manner	s of examina	owledge death ation and/or inv	occurred lestigation,	at the tim	e, data and inion, deat	place o	and due to the cau ed at the time, dat	me(s) and me and place,	and due to	aled the cause(s)
)	To the within To the comp	Me	29b. Signature and title of certifie	und)	>			License		4	1	d. Date signe		
1000	Sta Registr	-	30. Name and address of person Sesus 7 31. Date filed (Month, Day, Year)	N M D 32. Regi	of death (Iten	Broke	Print)	7	FROS	+6u	rg, MA	rylan	12	1532

			For S 1 - State Registrar	tate of Maryland		artment of H			ene 2	006	16107
			Decedent's Name (First, Middle, Last)					2. Date of Death	1		3. Time of Death
	Physicia		Philli	o G. Smi	th			Month OS	15	Year	11:08 AM
	/Medic Examin		4a. Facility Name (If not institution, give street			4b. City, Town, or	Location of Death			ty of Death	1
			W. 1	OSPITAL			ERLAND		AL	LEGAN	•
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpla Countr	
	Director		Usual Residence of Decedent	66	115,			9-18-	39		MD
	and ow		10a. State 10b. County	10c. City	, Town or Lo	cation				100	d. Inside City Limits
:	Many Figh	ţō	WV Mineral	Pie	dmont	. WV					1 ∏Yes 2 □ No
	or 28a-f ehow	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen o	f What Countr	y?
	23a o	aiD	79 W. Harrison	st.		2675	0		USA		
	dea me	Funerai	11. Marital Status 12.	Was Decedent Ever in U. Armed Forces?	S. 13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sr n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		ace - America lack, White, et	
2	or it		1 ☐ Never Married 2 🛱 Married	1 ∐ Yes 2 ₹No If Yes, Give		1□ Yes 2□No	Specify:		Spec	eify: Whi	to
Ś	iural'	d by		Year or Dates:		dent's Usual Occupa	ation		Sh Kind of	Business/Indu	
2	n /2 n "nai	Completed	15. Decedent's Education (Specify only highest grade control of the mpleted)	(Give	kind of work done of DO NOT use retired	furing most of work	king	OD. KING OF	Dusinosarino	istry	
7	iene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Mac	hinist			Fabri	icatio	n l
2	be tiled within 72 hours after death with the Maryland hal Hygiene. Nat Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at	0	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, N			
0	Alenta Alenta rked tic e	To B	William B. Sm:	ith			Regina	M. Ken	ny		
	permit. Pages I and 2 should be tiled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene in returnst, or items 23a or 28s-1 ehov any injury or other traumatic event, the Madical Examinal must be notified at once.		19a. Informant's Name/Relationship (Type,	Print)		ng Address (Street a			•		
	and and and and and and and and and and			Wife		. Harri	son St.				
9	Tite Tite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem	-	tace of Dispo emetery, cren	sition (Name of natory or other plac	θ)	Date	Oc. Location	n - City or Tow	n, State
altimor	tment tant:		4 □Donation 3 □ Other (Specify)	Sc		li Crem		-18-06_	Cumb	perlan	nd, MD
מפו	Depar Depar Impor any in		21. Signature of Funeral Service Licensee	1 17		Name and Address	,	1 Home	-31 5	Iones	st
	40340	_	23a. Part 1. Enter the disease, or complicate	one that caused the death							
			shock, or heart failure. List only one c	ause on each line.	. 0	1		10	1-10		Onset and Death
	hysician /Medical		disease or condition resulting in death)	Cancel	1	PRNC	reas	anon 1	22.40	SPOJIS	8 monte
	Examiner			H L Consequence	h -	10010	2 Vc	21 Pina	10		
	3.	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):	· Live		n m	-		
	cuted nd ransit	Examiner	that initiated events C.								
ĵ	be executed ician and burial-transi	EX	resulting in death) Last	Due to (or as a consequ	uence of):						
2	ate he he	dlcai	d								
Ď	eath certifica attending ph for use as t	Mec	IF FEMALE:	If you system a of proper							
X D	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregna 1 Live birth 2 Fetal	Ideath 3	Ectopic pregnancy				Date of delivery Month E	y Day Year
	law requires that the death as been signed by the atter 2 should be detached for t	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐ Unknown	ватп ос	Other (specify)					
7.	w requires that the de been signed by the a should be detached		Part II. Other significant conditions contrib	uting to death but not resi	ulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use co	ntribute to the	cause of death?
SD	uires sign ld be	d by						1 ☐ Ye	s 2 1 No	3 Proba	bly 4 ∐Unknown
000	w req	lete						24a. Was ar	246	o. Were autop:	sy findings available
Ē	tending Physician: The lav Jeath tor: After this certificate has the funeral director, page 2	Completed						autops: perform	ied?	death?	sy findings available pletion of cause of
VITAI	an: T tificat tor, pa	a	25. Was case referred to medical				26 Place of Dea	th (Check only one	No No	T Yes 2	2 □ No
2	ysici is cer direc	To B	examiner? 1 ☐ Yes 2√2 No	oital:	ER/Outpatier	nt 3 DOA Othe	26	ome 5 Reside		ther (Specify)	
0	ig Ph ter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	f 28c. Injun Worl	at k?	28d. Describe ho	w injury occ	urred	
NISION	aath or: A	atic	2 Accident investigation				Yes 2 □ No				
5	or Att	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	 Place of Injury - At he building, etc. (Specifical) 	ome, tarm, str y)	eet, factory, office		28f. Location (Sti City or Town		nber or Rural	Route Number,
_	urs al urs al eral D	O	202 C-451- 457 C-454-1 Bhusisi								
	To the Hospital or Attending Physician: within 24 hours state death to the Funeral Director: After this certifical completely filled in y the funeral director.	edical		 an: To the best of my kno On the basis of examina and manner stated. 							
	vithin o the	Me	29b. Signature and title of certifier	\cap		29c. License	e number	29	d. Date sign	ned (Month, D	ay, Year)
}			Dollar 14	Kracha	SIM	D D-	-175	26 1	107	15,	2006
	1		30. Name and address of person who comp	leted cause of death (Item	-	Print)		nberla	1		
	φ		011 00 114 110 10	anna 90		ton DRI	Ve, Cur	nberla	nol, 1.	nd a	1502
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 7 2006	32. Registrar's Signa	iture						
	riegisti	CII.	1111 (1 1 1	STATE STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE	THE STATE						

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar				Cei	tificate of	Death		F	Reg. No.		
			1. Decedent's Name (First,	Middle, La	st)					2.	Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Virginia	M.	Sai	nders				1	May	8	2006	12:40 P ^M
	Examin		4a. Facility Name (If not inst	itution, giv	e street and numb	oer)		4b. City, Town, o	or Location of	f Death		4c. C	County of Death	
	h B	dia dia	Oakland Nu					0aklan		14.11			Garrett	
	Funeral		5. Social Security Number	6. 5	ex 7 □M 2XDF	Age (In yrs.)	last birthday) Yrs.	If Under 1 Year Months Days		Min.	. Date of Birt (Month, Day	y, Year)	Cour	
1900	Director		220-76-4970 Usual Residence of Decede			88				J	uly 28	3 191	/ Wes	t Virginia
	land ow		10a. State 10b. C			10c. City	y, Town or Lo	cation					1	0d. Inside City Limits
	Mary -1 sh	tor	MD Ga	rett		0.	ak1and							X☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number					10f. Zip Code				10g. Citize	en of What Cour	ntry?
	death with the Maryland ims 23a or 28a-f show r must be notified at		517 S. Third	Stre	et			21550				Unit	ed Stat	es
	deat	Funerai	11. Marital Status		12. Was Deced		S. 13.	Was Decedent of I	Hispanic Orig	gin? (Specif	y Yes or No-		4. Race - Americ Black, White,	an Indian,
õ	or ite		1 Never Married 2		1 ☐ Yes 2 If Yes, Give	X No		1□Yes 21 No			,,	9	Specify:	
212-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Indoorber then "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at	d by	3 Widowed 4 □ Div		Year or Dat	es:							Whi	
7	"nat	Completed		edent's E	ducation ade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	of working		16b. Kind	d of Business/Inc	dustry
7 7	within 72 ene. than "nai	dmo	Elementary/Secondary (0	-12)	College (1-4	lor 5+)		emaker				Own	Home	
-	e filed v at Hygie other I	e C	17. Father's Name (First, M	iddle, Last)		110111		18. Mother	r's Name (F	First, Middle,			
/land	d be ental ked o	To B	Robert Jen	nings	Henry				Mary	Eliz	abeth	Lewi	S	
	2 should be and Mental Is marked raumatic ev	۲	19a. Informant's Name/Rel				19b. Mailir	ng Address (Street						Code)
<u>8</u>	nd 2 alth a 27 is		Roberta V. U:	nger,	Daughte	r	517	S. Third	Stree	t, Oa	kland,	MD	21550	
ē,	s 1 a if Hez Item othe		20a. Method of Disposition			1 ^	lace of Dispo	sition (Name of natory or other pla	ce)	Date	6	20c. Loc	ation - City or To	own, State
Ē	Page ient o nt: if ry or		XXBurial 2 ☐ Crem: 4 ☐ Donation 5 ☐ Oti			ate		Cemetery	,	5/11/	2006	0ak1	and, MD	
galtimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic enones.		21. Signature of Funeral Se	rvice Lice	nsee			. Name and Addre						Home
ñ	B = 10 B		Kathery	ne .	Durite				21 N.	Secon	d St.,	0ak	land, M	D 21550
9	4		23a. Part1. Enter the disea shock, or heart failure	se, or con List onty	plications that au	used the death	n. Do not ent	er the mode of dy	ng, such as c	cardiac or r	espiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			กรหลา	DIM	- 134	ain					Onset and Death
	/Medical		resulting in death)		a	as a consequ								9
	Examiner		Sequentially list conditions		b									
-	D H	iner	if any, leading to immediate cause. Enter Underlying	1	Dua to (o	as a curisequ	uanca of):						1	
	ecute and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	1	C. Dun to /o									
Š	be ex cian curial		,	- 1	Due 10 (0)	r as a consequ	derice or).							
68/60 ,	entificate be executed Jing physician and se as the burial-transit	Medical			_ d									
×		-	IF FEMALE:		23c. If yes, outco	ome of pregna	incv					22	d Data of dollar	201
0	death (e atten	Physician	23b. Was decedent pregna in the past 12 months		1 ☐ Live birt	h 2 □ Fetal nt at time of de	death 3	Ectopic pregnand Other (specify)	у			23	d. Date of delive Month	Day Year
j.	the d y the iched	ysk	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		9 Unknow			2 0 m o (
7	law requires that the as been signed by th 2 should be detache		Part II. Other significant co	nditions	contributing to dea	th but not rest	ulting in the u	nderlying cause gr	ven in Part I.		23e. Did to	bacco us	e contribute to the	ne cause of death?
as,	luires sigr lid be	d by									1 🗆 Y	es 2	No 3□ Prot	ably 4 Unknown
Hecord	w rec	Completed									24a. Was	an	24b. Were auto	psy findings available
e L	The la ate has page 2	duc									autop perfor	rmed?	prior to con death?	impletion of cause of
VItal		O	25. Was case referred to m	edical		77-No.			26 Place	of Death //	1 □ Yes Check only o	2 No	1 🗌 Yes	2 No
		0.8	examiner? 1 Tes 2 No		Hospital:	patient 2	ER/Outpatien	t 3 DOA Ot	- 4				☐Other (Specifi	v)
0		n: T	27. Manner of Death		28a. Date of		28b. Time of				d. Describe h			
<u></u>	Attending r death. ector: After by the fune	atio	2 Accident	ending vestigation	n	Su) rear/	injury		Yes 2 N	40				
UIVISION		Certification;	3 ☐ Sutcide 6 ☐ 0	ould not be etermined	e 28e. Place o	f Injury - At ho	ome, farm, str	eet, factory, office		28f	Location (S City or Tow	Street and	Number or Rura	il Route Number,
5	ital or rs afte el Dir	Cer												
	Hospital or 24 hours after Funerel Disterel Disterel bit letely filled in	edical	(Check only 2 Me	rtifying Pl dical Exa	nysician: To the b miner: On the bas	est of my kno	wledge, death	occurred at the ti	me, date and	d place, and	d due to the d	cause(s) a	nd manner as st	tated.
	To the h within 24 To the F complete	Medi	one)		and manne	r stated.								
	To To	-	29b. Signature and title of c	eruiler *	9	00	0	29c. Licens		t.l	1	zou. Date	signed (Month,	Day rear)
			" l'ack	Jun	ie no	100	O.	- 110		7 1	0 4 6 5	2	0	1 -6
	8		30. Name and address of p	erson who	completed cause	of death (Item	1 23a) (Type,	•	WOL	7-14	MA A	, UV	17-1-0	
3	Sta	to	31. Date filed (Month, Day,	Year)	1) E 32. Ray	istrar's Signa	ture	04	-Kly	nd	ANI D	1	17 1 0	
1	Registr		MAY	- 9	2006	2000 a	As A	Corollo 9						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death I. Decedent's Name (First, Middle, Last) **Physician** Harold 2006 8:00 A M Shockey, Sr. May 5, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Goodwill Mennonite Home Grantsville Garrett 8. Date of Birth
(Month, Day, Year)
Mar. 16, 1913 Arkansas If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□F 93 236-12-4954 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 367 Snow Dump Mountain Road 21550 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or its 1 XYes 2 No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. White ģ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter/Farmer Carpentry/Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Albert Shockey Alberta Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 367 Snow Dump Mountain Road, Oakland, MD Debra Corby/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. White Church Cemtery 5/7/2006 * 4 ☐ Donation 5 ☐ Other (Specify) Oakland, Maryland 21. Signalure of Funeral Service Ligensee 22. Name and Address of Facility 32 S. Second St. Stewart Funeral Home Oakland, Maryland 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lon **Physician** 25 heur y cor /Medical Due to (or as a consequence of) Examiner tro sc Cordiovoscu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and the detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical use as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💓 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No To the Hospitat or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Accident MD 21520 K. Naumann Walter 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 2006 Registrar

			1- For State Registrar	of Maryland / De	epartment of Certificate of			ene 2 () ()	5 16110
)	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) Harold Wayne 4a. Facility Name (If not institution, give street and		4b. City, Town	n, or Location of Death	2. Date of Death Month	Day Year 3 200	
	Funeral Director		Washington County Hosp 5. Social Security Number 218-30-7580 6. Sex □⊠ M 2□	7. Age (In yrs. last birtho	day) If Under 1 Ye		8. Date of Birth (Month, Day, Nov 21,	Washing 9. Bin C 1935 Mary	ngton thplace (State or Foreign ountry) aryland
-	the Maryland 28a-f ehow	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Washington 10e. Street and Number	10c. City, Town o	erstown				10d. Inside City Limits 1 ☐ Yes 2 🗷 No
ပ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: if item 27 is marked other than "natural", or items 23a or 28a-1 ehow apply injury or other traumatic event, the Madical Examiner must be multipled at ODGe.	Funeral	11943 Greencastle Pik. 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married	Decedent Ever in U.S. Forces? as 2 🖾 No		21740 of Hispanic Origin? (Sj luban, Mexican, Puert		g. Citizen of What C USA 14. Race - Am Black, Whi	erican Indian,
21215-0036	vithin 72 hours in ne. han "natural", c	Completed by	15. Decedent's Education (Specify only highest grade complete	or Dates: 16a. D.	fe. DO NOT use ret	cupation ne during most of work ired)	king	5b. Kind of Business	nite /Industry
Maryland 2	nould be filed was a Mental Hygie narked other tinatic event, the	To Be Co	17. Father's Name (First, Middle, Last) Charles Ellsworth Smi	th		Audre	ne (First, Middle, Ma ey Carbaug	gh	
	iges 1 and 2 st nt of Heatth and : if item 27 is n or other traur		19a. Informant's Name/Relationship (Type, Print) Shane W. Smith - son 20a. Method of Disposition → Burial 2 □ Cremation 3 □ Removal from	20b. Place of Dicametery,	943 Green isposition (Name of crematory or other p	olace)	Date 20	stown, Md. Oc. Location - City or	21740 Town, State
Baltimore,	permit. Pa Departmen Important any injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Manuel	Lawn Mem. 22 Name and Add 415 E. W	dress of Facility	MINNICH l., Hagers	FUNERAL H	
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) Due	to (or as a consequence of):	n min	1	or respiratory arres)	Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the buriat-transit	dical Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events c.	to (or as a consequence of): (or as a consequence of): (or as a consequence of): (or as a consequence of):	n M	setes			
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cords, P	tw requires that the de- s been signed by the a ? should be detached fo	Completed by Pl	Part II. Other significant conditions contributing to Congartine See See Was	o death but not resulting in the	e underlying cause	given in Part I.		2 □ No 3 □ Pr	o the cause of death? obably 4 □Unknown ttopsy findings available
/ital Re		Be	25. Was case referred to medical examiner?				autopsy performe	d? prior to death?	completion of cause of 2□ No
Division of Vital Records,	ten leat tor: the	Certification; To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (M 2 ☐ Accident investigation investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investigation and investi	te of Injury 28b. Tim onth, Day Year) Injur	e of 28c. In W	ury at /ork? ☐ Yes 2 ☐ No	28d. Describe how		
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ر	To the Hospitel within 24 hours a To the Funeral I completely filled	Med	29b. Signature and title of certifier	armer stated.		nse number 0 58113		Date signed (Monti	
	Sta	to.	30. Name and address of person who completed ca	ause of death (Item 23a) (Type Anticlo	pe, Print)	Hrg. M	nd 217	40	
	Registr		MAY 0 8 2006	Draw D. S.	fortes	•			

			1 - State Registrar	State of	Maryla		artmen <i>rtificat</i>			and M	lental Hy	giene Reg. Na	C 1	06	16	The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon
	Physici		Decedent's Name (First, Middle, Lass Assunta Sabella	it)							2. Date of De Month May 4,	Da	 86	Year	3. Time 8:50	of Death
	/Medic Examir		4a. Facility Name (If not institution, give		рөг)		· ·		Location o	of Death	,	40	. County	of Death		
	Funeral Director		5. Social Security Number 6. S 099–10–7489		Age (In yrs	. last birthday) 3 Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Aug. 1	46-			place (State intry) KLyn,	e or Foreigr NY
	he Maryland 8a-f show	Director		George'		ity, Town or Lo Mitchel	lvill									City Limits es 2 ☐ No
	h with th		3800 Lottsford	Vista Rd			10f. Zip		721			10g. Ci	tizen of V US	Vhat Cou A	intry?	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It has the marked other than "natural", or items 23a or 28a-f show other traumatic avant, the Medical Examinations to notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? ☑ No		Vas Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	*		k, White	can Indian, etc. ite	
21215-0036	e filed within 72 ho al Hygiene. other than "natur vant, II'e Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12th	ucation de completed) College (1-4	or 5+)	life. I	tent's Usua kind of wor DO NOT us Homem	rk done a se retired,	<i>uring</i> most)	of worki	ng	16b. K		usiness/ir	.,	
	be filed stal Hygi ad other avant, I	Be	17. Father's Name (First, Middle, Last)	i aabi a			HOHEN	axel			(First, Middle,			wn H	one	
Maryland	2 should be and Mental is markad o	To.	Alessandro Cal. 19a. Informant's Name/Relationship (7	уре, Print)						r or Rura	ina Noo	er, City o				
di.	item 27 l	i j	Patricia Brenna 20a. Method of Disposition	an/ Daugl	20b.	Place of Dispo	sition (Nam	ne of	1		Colleg				207 own, State	40
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		1 Aurial 2 □ Cremation 3 X `4 □ Donation 5 □ Other (Specify			cemetery, cren Lnelawn	Memo	rial	Park		/09/06			awn,		
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licen	PM	Jaen	6	512 N	W C	s of Facility rain	Hwy	LL Fune Bowie,	, MD		e 715		
	Pnysician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Card	n ine. LOMYOR	pathy	er the mode	e of dying	, such as o	cardiac o	r respiratory ar	rest,			Approxim Interval Bi Onset and Years	etween
P	Examiner			Debi.	-										Years	
,00	icate be executed physician and sthe burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	c. Chro	as a consecution of as a consecution	struct	ive P	ulmo	nary	Dise	ase				Years	
.O. Box 68760,	death certifi e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	d	2 Feta t at time of c	al death 3 🗌	Ectopic pre Other (spe						23d. Date Mor	e of deliver	ary Day	Year
Δ.	es the	by	Part II. Other significant conditions or	entributing to deat	h but not res	sulting in the un	derlying ca	iuse give	n in Part I.			es 2			ne cause of	
Vital Records,		e Completed	25. Was case referred to medical						00 81	-10		sy med? 2 No	p	Vere autorior to coeath?	psy findings mpletion of 2 No	s available cause of
Division of Vi	문 + E	ToB	examiner?	28a. Date of I		EP/Outpatient 28b. Time of Injury		Other Bc. Injury Work	4 ⊠ Nur	sing Hon 2	Check onlog ne 5 Resid 8d. Describe h	ence (y)	
Divis	in the second	Certification:	3 Suicide 6 Could not be determined	28e. Place of building,	Injury - At h etc. (Specia	ome, farm, stre	et, factory,	office		2	8f. Location (S City or Tow	treet and n, State	d Numbe)	r or Rura	l Route Nui	nber,
	To the Hospital within 24 hours a To tha Funaral Completely filled	edical	29a. Certifier Check only one) Certifying Phy 2 Medical Exam	sician: To the be iner: On the basis and manner	s of examina	owledge, death tion and/or inv	occurred a estigation,	it the time in my opi	, date and nion, death	place, a occurre	nd due to the o	ause(s) late and	and mar place, a	ner as si nd due to	ated. the cause(s)
)	To the To the Complet	Me	29b. Signature and title of certifier	ous	19	MD	29c.	License	number 2 o	108	1	9d. Dat	e signed	(Month,	Day, Year)	
	(8)		30. Name and address of person who co				,	EOS	r Tang	2 511	ite 222	Ro	vi o	MD	20715	
	Sta Registra		31. Date filed (Month, Day, Year) MAY 0 8 2006	A. Regi	strar's Signa		BI	202		<u> </u>		100	, <u>re</u> ,	LIL	20/15	,

OHMH 17 Rev 1/2001

Bessie Benita Swindler

Please Type or Print in Black Indelible Ink

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State of Maryla	and / Departr	nent of Health ar	nd Mental Hygiene

		1- For State Registrar		С	ertific	ate of	Death				eg. No.	< U L	10 6
Physicia Medical Exami		Decedent's Name (First, Midd Bessi		windle:	r					. Date of Dea Month	Day Y	ear	3 Time of Death
Wedical Exami	ilei	4a. Facility Name (if not institution				14	b. City, Town, o	r Loostian		April 29, 2	2006		0936 hrs
		Prince George's Hosp		amber,		7	Cheverly	Location	or Death		4c. County Prince		
Funeral		Social Security Number	6. Sex	7. Age (In yr	s. last birt	hday)	If Under 1 Yea	ar If Und	er 24Hrs.	8. Date of Bir		_	rthplace (State or
Director		578-98-8649	1 M 2 X F	40	i	Yrs.	Months Day		e Min			Foreig	ountry) Wash, DC.
		Usual Residence of Decedent	221	40		113.			لــــــــــــــــــــــــــــــــــــــ	Januar	y 30, 130	9	wash, DC.
any		10a. State 10b. County	_	10c. C	ity, Town	or Location				·			10d Inside City Limits
and show		Maryland Prin	ce George				Fores	tvil	Le				1 X Yes 2 No
Maryland 28a- f show any <u>d at once.</u>	Director	10e. Street and Number					10f. Zip Code			11	0g. Citizen of V		*
the ?		1762 Forest	Park Dr.				20747				United	Sta	tes
h with	uneral	11. Marital Status	A 1 F	cedent Ever in	U.S.		Decedent of Hi s, specify Cuba						ican Indian, Black,
r deal	Fun		1 Yes	2 X No						can, etc.)	VVIII	te, etc	
rs afte rral",	2	Widowed 4 Div 15. Decedent's Education (Spe	orced if Yes, Give Yes or Dates:		140-1		Yes 2 X No				Specify.		lack
2 hour	ted	Elementary/Secondary (0-12)	College (1				s Usual Occupa st of working life				16b. Kind of B	usiness/I	Industry
36 Thin 7 te. than	Completed	12th		,	St	ecia	1 Polic	e			Law	Enfo	rcement
5-00 ed wii lygier other	S	17. Father's Name (First, Middle,	Last)	-	1 -1				's Name (F	irst, Middle, N	Maiden Surnam		T C C III C II C
215 be fill ntal F rked	Be	William Moore					Í	Doro	othy S	Swindle	er		
MD 21215-0036 d 2 should be filed within 7 th and Mental Flygiene. n 27 is marked other than numatic event, the Medica	٤	19a Informant's Name/Relations									nber, City or To		, Zip Code)
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygene. ten 27 is marked other than "natural", or items 23a or 28a-f shorrannatic event, the Medical Examiner must be notified at once.		De'Angelo Hol	ley/Son								ville, l		20747
or Hee	ų	20a Method of Disposition 1 X Burial 2 Cremation	n 3 Removal fr			of Disposit ory or othe	ion (Name of ce er place)	metery,		Date	20c. Location	- City or	Town, State
imC Page ment tant:		4 Donation 5 Other S	pecify:	F	ort	Linco	oln Ceme	etery					, MD.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traunnatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	1001	/	22. Na	me and Addres	s of Facility	y PC	pe Fur	ieral H	mes Pika	
Physician	-	23a. Part I. Enter the disease, or	complications that o	aused the de	Do no	t optor the	mode of duice	auch as a	H.C	restvi	III P. MI)	20747
/Medical		failure. List only pre cause	on each line								est, snock, or he	art	Approximate Interval Between Onset and
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	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence	e of):				-				
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8760, tificate be ng physic as the bur	Ě	IF FEMALE: 23b Was decedent pregnant in th	23c. If yes,	outcome of pr	. ,						23d. Date o		
Sox 68 teath certiff at the attending for use as		past 12 months?	I I Live D	ant at time of	death 5		I death 3 er (Specify)	Ectopic	pregnancy	/	Month	D.	ay Year
Box e death c the atten	Physicia	1 Yes 2 No 9 V Unk	9 Unkno	own	J	Othe	(Specify)						
.O. Bhat the ded by the etached		Part II. Other significant conditi	ons contributing to	death but no	t resulting	in the un	derlying cause o	given in Pa	art I.	23e. Did tol	bacco use conti	ibute to the	he cause of death?
ires the signe	d by									1 Yes	2 ✔ No 3	Proba	ably 4 Unknown
ords * requ shoul	Set									24a. Was a autops			opsy findings available ompletion of cause of
he lay	Completed	-								perform	med?	death?	
tal R cian: T certific ector, p	Bec	25. Was case referred to medical					26.Place	of Death	(Check only			✓ Yes	s 2 No
Vita hysici this o	일	examiner? 1 ✓ Yes 2 No	Hospital: 1	npatient 2	✓ ER/Ou	tpatient	3 DOA	Other ₄	Nursing H	lome 5 F	Residence 6	Other.	
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that it is after death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be deace.		27. Manner of Death 1 X Natural 5 Pend	28a. Date (Month.	of Injury , Day,Year)	28b. T	ime of Inj	ury 28c. Inju	ry at Work	? 28	d. Describe h	ow injury occur	ed	
ior tfend death. ctor:	atie	- I CITO	ing stigation				1`	Yes 2	No				
Divisipital or At ours after deral Direct filled in by	Certification:	3 Suicide 6 Could	d not be 28e. Place	e of Injury - At	home, fai	rm, street,	factory, office b	ouilding, etc	c. 28	f. Location (Stor Town, St.		er or Rura	al Route Number, City
Division spital or Attend hours after death meral Director;	Ö	4 Homicide	mined (Specify)						- 4				//
Division of Vital Records, P.O. Box 68760, To the Hospital or Atending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Exam	nysician: To the bes	t of my knowle of examination	edge, dea and/or in	th occurre	d at the time, da	ate and pla	ice, and due	e to the cause	e(s) and manner	as starte	ed.
To 1 With To 1	Med	29b. Şignature and title of certifie	and manner st	tated			29c. Licens		odi i od di (i i	Time, date a			
	-1	Man - A	11/				O.C.I			ļ	April 30, 20		ш, ⊅ау. теаг)
	-	30. Name and address of person	who completed cause	e of death (its	m 23a)						p.11 00, 20		
1R		Margarita Korell MD.	Assistant Med	,	,	111 Per	nn Street, B	altimore	, MD 212	201			
	-	31. Date filed (Month, Day, Year)		gistrar's Sign	ature	2.00							
Regist	rar	MAY 1 6 20	NO ADD	w A	17	TO THE							

	State of Maryland / Department of Health and Men	
	For State Certificate of Death Registrar Certificate of Death	Reg. No. 006 6 3
Physician /Medical	Eulah Oshers	Date of Death Month Day Year 3. Time of Death Month Month Day Year 06 09574 M
Examiner	Facility Name (Mont institution, give street and number). 4b. City Town, or Location of Death CORP Ocial Security Number. 6. Sex 7. Age (In vis. last birthday). If Under 1 Year If Under 24 Hrs. 8 If	40. County of Death MNCL PENTES
Funeral Director	15-76-5181 1□ M 202F 78 Yrs. Months Days Flours Min.	Date of Birth Month, Day, Year) 9. Birthplace State or Foreign Country GUYANA, SA
yland	nal Residence of Decedent . State 10b. County 10c. City, Town or Location	10d. Inside City Limits
death with the Maryland rms 23e or 28e-f show rmust be nutflied at	MD PRINCE GEORGE S HYATTSVILLE Street and Number 10f. Zip Code	1 Yes 2 □ No 10g. Citizen of What Country?
23a or	305 RIGGS RD # 306 20783	U.S.A.
ē 2 3 5	Marital Status 1 □ Never Married 2 ■ Married 1 □ Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ■ No If Yes, Give Year or Dates: 1 □ Yes 2 ■ No Specify:	Yes or No- n, etc.) 14. Race - American Indian, Black, White, etc. Specify: BLACK
n 72 hours	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Ind 21215-00 be filed within 72 ho tal Hygiene. d other then "natural other then "natural ovent, it is Madical Be Completed	College (1-4or 5+) 2 yrs College (1-4or 5+) NURSE	PRIVATE
be fill be to the seven	Father's Name (First, Middle, Last) EGBERT BURGZORG MAISIE FR	rst, Middle, Maiden Surname) REEMAN
Maryla d 2 should th and Mer 7 is marke traumatic	a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Ro	ute Number, City or Town, State, Zip Code)
	JOAN P GEORGE/DAUGHTER 2021 3rd STREET N.E. WASH Method of Disposition 20b. Place of Disposition (Name of Date	HINGTON, DC 20002 20c. Location - City or Town, State
Pages nent of int: if it	1 ②Seurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	
Baltimore, permit. Pages 1 at Department of Hee Important: if item any injury or otha		Jenkins Funeral Home NDOVER,MARYLAND 20785
be executed be executed be executed burial-transit burial-transit burial-transit all Examiner	a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dyint, such as cardiac area shock, or heart failure. List only one cause on each line. mediate Cause (Final ease or condition ulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	spiratory arrest, Approximate Interval Between Onset and Death
Records, P.O. Box 68760, The law requires that the death certificate be execute the has been signed by the attending physician and age 2 should be detached for use as the burial-trant completed by Physician/Medical Exam	d. Z3c. If yes, outcome of pregnancy in the past 13 months? Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
by the a tached tached thysic	4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown	
cords, P	t II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 ♣ Unknown
		24a. Was an autopsy performed? 1 Yes XNo 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes XNO
of Vita Physician: this certific ral director, TO Be C	Was case referred to medical examiner? 1 Yes 2 No Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Ser	seck only one) 5 Residence 6 Other (Specify)
Jing After After tune	Manner of Seat 28a. ate of Injury 28b. Time of Injury 2 Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Accident 28d. Ac	Describe how injury occurred
_ es s = 0	3 ☐ Suicide 4 ☐ Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ocation (Street and Number or Rural Route Number, City or Town, State)
The Hospital in 24 hours a the Funaral I pletely filled	a. Certifier (Check only one) Check only one) Add Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and of some one of the time, date and place, and of some one of the time, date and place, and of some one of the time, date and place, and of some of the time, date and place, and of some of the time, date and place, and of some of the time, date and place, and of some of the time, date and place, and of some of the time, date and place, and of the time, date and place, and of the time, date and place, and of the time, date and place, and of the time, date and place, and of the time, date and place, and of the time, date and place, and of the time, date and place, and of the time, date and place, and of the time, date and place, and of the time, date and place, and of the time, date and place, and of the time, date and place, and of the time, date and place, and of the time, date and place, and of the time, date and place, and of the time, date and place, and of the time, date and place, and of the time, date and place, and of the time, date and place, and of the time, date and place, and the time, date and place, and the time, date and place, and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time,	due to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)
To the within To the comple	o. Signature and title of certifier 29c. License number	29d. Date signed (Month/ Day, Year)
1 (1)	(Juliu 9303/8	5/1/06
R(1)	Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES CATEVENIS M.D. 3001 HOSPITAL DRIVE LANDOVER, MARY	ZLAND 20785
State Registrar	Date filed (Month, Day, Year) MAY 0 5 2006 MAY 0 5 2006	

		•	For State Registrar	State of Marylar		artment of F tificate of		F	Reg. No 0 0	6 16114
	Physici	an	1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month	Day Ye	
	/Medic		BEN	J.	SM	ITH Jr		MAY	2 2006	6:51 P M
	Examin	er	4a. Facility Name (If not institution, give			CLINT	r Location of Death		4c. County of E	GEORGE 'S
	Funeral		CLINTON NURSING 5. Social Security Number 6. S		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt.		Birthplace (State or Foreign Country)
	Director		577-66-4396	2 M 2 □ F 59	Yrs.	Months Days	Hours Min.	(Month, Day APRIL 8		RGINIA
	D .		Usual Residence of Decedent 10a. State 10b. County	10c C	ty. Town or Lo	cation				10d. Inside City Limits
	Aaryla F sho	ō								Yes 2 □ No
	28a-1	Director	MD PRINCE G	EORGE'S	CAPITAL	HEIGHTS 10f. Zip Code			10g. Citizen of Wha	t Country?
	deeth with the Maryland me 23s or 28s-f show f must be notified at	io le	7 VALE PLACE			20743			U.S.A.	
	deeth	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. Y		lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No-	14. Race - /	American Indian, Vhite, etc.
2-0030	n 72 hours after deeth with the Marylan "natural", or itame 23e or 28e-f show edical Examinat must be notified at	ğ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tayes 2 □ No Ar If Yes, Give Year or Dates:	mv	I∐Yes 2⊠ No	Specify:	110411, 0101,	Specify:	BLACK
ה ה	72 ho	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced (Give	ient's Usual Occup kind of work done	ation during most of worki d)	ng	16b. Kind of Busin	ess/Industry
7	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired ECTIONAL			DC GOVERN	MENT
N	filed v Hygie ther t		17. Father's Name (First, Middle, Last)		COKK	CITONAL	18. Mother's Name			ILITZIAT
yland	ntail ed o	To Be	BEN JAMES SMITH				LULA EL	ZABETH	LEWIS	
Ξ.	should Ind Men	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	g Address (Street	and Number or Rura	l Route Numbe	r, City or Town, Sta	te, Zip Code)
Ma	is 1 and 2 should of Health and Me Itam 27 is mark other traumation		VALENCIA SMIT	TH/WIFE	7 VAI	LE PLACE	CAPITAL H	EIGHTS,	MARYLAND	20743
more	Pages 1 and of He int: If Itam		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, crer	sition (Name of natory or other place ANS CEME	TERY 5/11	/2006	20c. Location - City CHELTENH	or Town, State
Balt	permit. Page Depertment of Important: If any Injury or once.		21. Signature of Funeral Service Licen	·	hove	. Name and Addre	ss of Facility J.		CINS FUNEI	
			23a. Part1. Enter the disease, or compshock, or heart is ure. List only	plications that caused the dea one cause on each line.						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse		ARDIO VA	SCULAR DIS	SEASE		
	Examiner		Sequentially list conditions.	b						
	pe jist	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence or):					
P	licate be executed physicien and s the burial-transit	Examine	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):					
2/P	e be e	edical E		d						4
0	tificat 19 phy as th							-		
C. BOX	it the death certifi by the attending tached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	aldeath 3	Ectopic pregnancy Other (specify)	<i>'</i>		23d. Date of Month	delivery Day Year
7	law requires that the es been signed by th 2 should be detache	by Ph	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
g	quires n sign							1 🗆 Y	′es 2 ☐ No 3 ☐	Probably 4XUnknown
ecoras,	aw requir s been si 2 should	Completed						24a. Was		autopsy findings available
Ţ	و ج و	E O						autop perfor 1 🗀 Yes	med? deat	to completion of cause of h? Yes 2 % No
VII	sician: Th certificete rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Death			- A
> 0	Physician: this certific ral director,	2	1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2			4 M Nursing Hor	ne 5 Resid	lence 6 Other (S	Specify)
	After After fune	Certification:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □No	28d. Describe h	ow injury occurred	
DIVISION	of or Attending after death. I Diractor: After In by the fune	ifica	3 Suicide 6 Could not be determined	9 28e. Place of Injury - At I	iome, farm, str					r Rural Route Number,
5	를 를 들	Cert	4 Homicide	building, etc. (Spec	ny)			City or Tow	m, State)	
	To the Hospital within 24 hours of To the Funeral I completely filled	edical	29a. Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death ation and/or in	n occurred at the tirvestigation, in my o	ne, date and place, a pinion, death occurre	and due to the deed at the time, o	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the To the Complet	Σ	29b. Signature and title of certifier			29c. Licens	e number	-	29d. Date signed (M	onth, Day, Year)
	(m gide	200	· · · · · · · · · · · · · · · · · · ·	D453	365		MAY 4	, 2006
_	(10)		30. Name and address of person who MICHAEL G. SII	DAROUS M.D. 1	1701 L	LVINGSTON	ROAD # 1	01 FT.	WASHINGTO	N,MD 20744
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 5 200	Registrar's Sign	ature do	E.				
	3.0		MMI U 3 200	The same of	-/					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] § 1 - For Stete Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2006 11:25P.M May Lee Shapiro Tabb /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Hebrew Home of Greater Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Dec. 4, 1910 9. Birthplace (State or Foreign **Funeral** 1□M 2□F Days Hours Washington, D. Director 95 579-40-3470 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health, and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, If a Madical Examiner must be notified at once. 28a-f show Silver Spring Yes 2 No Maryland Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3210 N. Leisure World Blvd., # 103 20906 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐Yes 2X No Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: If Yes, Give Year or Dates: þ 3 ☐ Widowed 4√☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical D. C. Government 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mollv Mendelson 2 Jacob Shapiro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3210 N. Leisure World Blvd., # 103, Silver Spring Dr. Marvin N. Tabb - Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Judean Mem. Gardens 5/9/2006 Olney, Maryland * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc.
1091 Rockville Pike, Rockville, Maryland 21. Signature of Funeral Service 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LZ /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner aftending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) the 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? 2 1 ☐ Yes 2/☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 ☐ Yes 2 700 1 Yes Vital Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐ No. 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA oţ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mariner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Division Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation affer death Diractor: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerel D McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) W 10 cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed

DHMH 17 Rev 1/2001

State

Registrar

554

09

2006

31. Date filed (Month, Day, Year)

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 19ar per land 8856 6-7-06 Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year 1330 PM Thomas 2006 Blair 05 08 stephen 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death VAMEdical Center BRLY SALTIMURE DRHIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) Days Hours Min 1 □ M 2 □ F 187-40-9518 Yrs. 56 06 PA Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Fulton Burnt Cabins 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17215 P.O.Box USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status No 1 Yes 2 No 1 Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: White 3 □Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse 12 Laborer-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) C. Thomas John Dorothy M. McGarvey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17233 211 Woodside Dr.Apt.B-11Mcconnellsburg, Pa. 19a. Informant's Name/Relationship (Type, Print) Thomas (Son) Justin C. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Geisel crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/13/06 Chambersburg, Pa. 22. Name and Address of Facility Howard L.Sipes Funeral Home 21. Signature of Funeral Service Licensee fr. M01035 875 LincolnWay E. McConnellsburg, Pa17233 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) anoxic orain Muny Due to (or as a consequence of) obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

PA

Director

Funeral

Completed by

Be

Funeral

Director

r then "natural", or items 23a or 28a-f ehow the Medical Examinar must be notified at

other then

permit. Pages 1 and 2 should be file.
Depetment of Health and Mental Hyg.
Important: if Item 27 is marked other
eny injury or other traum-17.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records.

Division of Vital

ernitta

attending physicien and for use as the burial-transit

To the Hospital or Attending Physicien: The law requires that the death certificate be executed Pis After this death. Director: /

within 24 hours a To the Funerel L 10+1VA State

after

Examine Physician/Medical ģ Completed ဥ Certification:

IF FEMALE: 23b. Was decedent pregnant 9 Unknown

in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

1 Yes 2 → No

27. Manner of Death

1 HNatural

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

Medical

4 | Homicide

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

autopsy performed

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes

1 ☐ Yes 2 11/10 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Tes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

3□ DOA

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29b. Signature and title of certifier elm MD

AU4167435 M16779

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

1 hpatient

Meenaghar 31. Date filed (Month, Day, Year) MAY 10 2006

5 Pending investigation

32. Progistrar's Signature

ION GREENESTERET BALTIMURE, MD 21201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000

			1 - State Registrar		Cei	rtificate of De	eath	Reg	. No.	
I	Physic	ian	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	Margaret Mary TROS 4a. Facility Name (If not institution, give			4b. City, Town, or Lo	postion of Dogth	May 9	2006 4c. County of Death	1.50 HM
1	Examir	ner	Kline Hospice Hous	·		Mt. Air			Frederic	a k
	Funeral		Social Security Number 6. Se.	x 7. Age	(In yrs. last birthday)	If Under 1 Year II	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		place (State or Foreign ntry)
	Director		164-22-0/15	⊐м Ж Т	78Yrs.	Months Days		Feb. 13		sylvania
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Many -f sho	ō	Marvland Washing	ton	Насог	stown				1∏Yes 2□No
	h the	Director	10e. Street and Number	2011	nagei	10f. Zip Code		10g	. Citizen of What Cou	ntry?
	23a c		305 Sunbrook Lane			21742	2		USA	
	hours after deeth with the Maryland turet', or items 23s or 28s-f show all Exercities could be notified at	Funerai		12. Was Decedent E Armed Forces?		Was Decedent of Hispa f Yes, specify Cuban, I	anic Origin? (Spi Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
36	rs aft	by F	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 ☐ Yes 2 🕅 N If Yes, Give Year or Dates:	•	1□Yes 2∏ No S	Specify:		Specify:	
2-0036	72 hours "neturel",	ted	15. Decedent's Edu	ucation	16a. Deced	dent's Usual Occupation	on	16	b. Kind of Business/Ir	
212	within 72 ho ene. then "netur he Medicel	Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5-	(Give	kind of work done duri DO NOT use retired)	ing most of work	ng		,
7		ဦ	0-12	0	C1	erk			ry Cleane	rs
Maryland	ed at b	Be	17. Father's Name (First, Middle, Last)					(First, Middle, Ma	iden Sumame)	
<u> </u>	2 should and Me ie mark aumatic	ဥ	John Michalek 19a. Informant's Name/Relationship (Ty	voe Print)	19h Mailin	ng Address (Street and	lary Gim		ihr or Tourn State Zin	Codel
	s 1 end 2 should t Health and Mer Item 27 is marks other traumatic		Gerrianne Hammond			Portsmout				
Baltimore,	of Hear Item		20a. Method of Disposition		20b. Place of Dispo-				c. Location - City or To	
Ĕ	Pages ment of ant: if it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		1	s Cemetery	5/12	/06 Na	inticoke, I	Pa.
Ž	permit. Pages Department of I Importent: if its any injury or o	1	21. Signature of Funeral Service Licens	00		. Name and Address of			neral Home	
_	00 E € 0		Fred L.V	estal		5 E. Wilso			own, Md. 2	21740
y,			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line	9.			· · · · · ·		Approximate Interval Between Onset and Death
	Enysician /Medical		disease or condition resulting in death)	a. CONGE	Consequence of F	HEMRI	1/11	LURE	/	week
	Examiner			ATRI	AL FI	BRILLA	471	oN	,	week
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):			7		or core
	and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	o,						
Ď,	be exicien a	E	resulting in Geath) Cast	Due to (or as a	consequence of):					
09/89	tificate be executed ng physicien and as the burial-transit	ledicai		1						
_			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o					23d. Date of delive	arv.
0	0 0	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2 4☐Pregnant at t		Ectopic pregnancy Other (specify)			Month	Day Year
л Э	at the by th	hys	9 Unknown	9□ Unknown						
_	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions cor	itributing to death bu	t not resulting in the un	nderlying cause given in	Part I.		co use contribute to the	ne cause of death?
Ś	equi sen s ould	ted	CORUNARY	ME.						
oras,	- 9-5					7200	0	T Tes	2 No 3 Prob	ably 4 Donknown
ecord	> 0 0	mple				7,300		24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
Hecord	> 0 0	Completed	OF Was and obtained to California			7200		24a. Was an autopsy performed	24b. Were auto prior to con death?	psy findings available appletion of cause of
VII al Record	> 0 0	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital: 1 □ Innation	t 2 SR/Outpatien	1 04		24a. Was an autopsy performed 1 Yes 2 Check only one	24b. Were auto prior to con death? No 1 \(\superscript{Yes}	psy findings available inpletion of cause of 2 No
or vital Record	Physician: The law this certificete has b al director, page 2 si	To Be	examiner? 1 Tyes 2 No	28a. Date of Injury	28b. Time of	3 DOA Other:	4 ursing Hor	24a. Was an autopsy performed 1 Yes 2 Check only one	24b. Were auto prior to cordeath? 10 1 1 Yes	psy findings available inpletion of cause of 2 No
or vital Record	ding Physician: The law n. After this certificete has b funeral director, page 2 si	To Be	examiner? 1 Yes 2 No F 27. Mannes of Death 1 Natural 5 Pending 2 Accident investigation	1 Unpatien	28b. Time of	Other: 28c. Injury at Work?	4 ursing Hor	24a. Was an autopsy performed 1 Yes 2 (Check only one)	24b. Were auto prior to cordeath? 10 1 1 Yes	psy findings available inpletion of cause of 2 No
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vision of Vital Record	To the Hospital or Attending Physician: The law thin 24 hours after death. To the Funsral Director: After this certificete has b completely filled in by the funeral director, page 2 st	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. sician: Tu the basis of and manner state.	Year) 28b. Time of Injury y - At home, farm, stre (Specify) my knuwladgs death examination and/or invent.	28c. Injury at Work? M 28c. Injury at Work? M 1 Yes set, factory, office cocurred at the tale, cestigation, in my opinic	2 No	24a. Was an autopsy performer 1 Yes 2 (E) [Check only one) ne 5 Residence 18d. Describe how 28f. Location (Street City or Town, S) and Jue to the cause at the time, date 29d.	24b. Were auto prior to cordeath? 1 Yes e 6 Other (Specify injury occurred at and Number or Ruralitate) c(s) and manner as st and place, and due to	psy findings available inpletion of cause of 2 No No No Route Number, atcd. the cause(s)
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			1 - For State Registrar	State of Mary	land / Depa		Health and N	Mental Hygi	•	8		
	Physici /Medi Examir	ċal.	Decedent's Name (First, Middle, Last Joseph David A. Facility Name (If not institution, give	Villa:	nova	4b. City, Town,	or Location of Death	2. Date of Death Month April	Day Year 3. Time of Death 12:35 P			
	Funeral Director		191-24-7779		yrs. last birthday) Yrs.	Oaklat If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,) Oct. 14,	Garrett 9. Birthplace (State or Forei Country) 1929 Pennsylvania	gn		
	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28e-1 show to Medical Evarurer must be notified at	ector	Usual Residence of Decedent	100	c. City, Town or Lo				10d. Inside City Limi 1 ☐ Yes 2√2 N			
	eath with is 23a or 3	erai Dir	126 Leo Friend R	oad 12. Was Decedent Ever	in II S 12 1	10f. Zip Code 21550	Jiangaja Osiaja? (Sa		g. Citizen of What Country? United States			
3036	iours after de Irel', or Item I Examiner	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 ANo If Yes, Give Year or Dates:		was Decedent of the first of t	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecry Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
21215-0036	s within 72 h piene. r then "natu Ine Medica	ompiete	15. Decedent's Edu (Specify only highest grace Elementary/Secondary (0-12) 1.2		(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of work id)	ing 16	Sb. Kind of Business/Industry Auto			
Maryland 2	outd be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) Joseph	Villanova			Alyce	Name (First, Middle, Maiden Surname)				
re, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Importent: If item 27 is marked other then "naturel", or items 23a or 28e-1 show amy injury or other traumatic event. The Medical Evantment must be notified at ODGS.		19a. Informant's Name/Relationship (T) Margaret Villano 20a. Method of Disposition	va, Wife	P.O.	Box 203	, McHenry,	MD 215	City or Town, State, Zip Code) 41 Dc. Location - City or Town, State			
Baltimore,	permit. Pages Department of Importent; If i any injury or once.		1 ☐ Burial 2 [XCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		Cumberland Crematory 5/3/06 Cumberland Cumberland Burdock-Durst Funera							
Ĺ	Priysician /Medical Examiner			a. Aortic ar	death. Do not ent	21 1 erthe mode of dyi pheral	N. Second ng, such as cardiac o	St., Oak or respiratory arres	1and, MD 21550 t, Approximate Interval Between Onset and Death			
,160,	te be executed ysician and ie burial-transit	cai Examiner	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. history of Due to (or as a core of ASCVD	obstruc				yrs yrs	-		
.O. Box 68	Attending Physicien: The law requires that the death certificate be executed rr death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Media	IF FEMALE:	23c. If yes, outcome of pro 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 □	Ectopic pregnanc Other (specify)	у		23d. Date of delivery Month Day Year			
ords, P	w requires that been signed k should be deta		Part II. Other significant conditions co hyperlipidemia	ntributing to death but not	resulting in the ur	nderlying cause giv	ven in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknow	'n		
tal Record	icien: The law certificate has b rector, page 2 sl	e Completed	25. Was case referred to medical				26. Place of Death	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No	Θ		
of Vi	Physicien: this certificatal director, I	: To B	examiner? 1 Yes X No 27. Manner of Death	lospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatien	t 3 DOA Ott	ner: 4 Nursing Ho	me 5 X Residenc	ce 6 Other (Specify)			
Division of Vital	or Attending Phatter death. Director: After the in by the funeral	Certification:	1XX Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	(Month, Day Yea 28e. Place of Injury - A building, etc. (Sp	f) Injury At home, farm, stre	M 1	k? Yes 2 □ No	28d. Describe how 28f. Location (Stree City or Town, S	at and Number or Rural Route Number,			
_	To the Hospital or A within 24 hours after To the Funerel Dire completely filled in by	edicai Ce	29a. Certifier to Certifying Phy (Check only one)	sicien: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the tire restigation, in my o	me, date and place, a ppinion, death occurr	and due to the caused at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)			
	To the To the Comp	Me	29b. Signature and title of ceptifor	Katar	2	29c. Licens D300			Date signed (Month, Day, Year) -01-2006			
	4		30. Name and address of person who contains a second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon	chter, M.D	1533	•	ial Driv	e-Oakla	nd MD 21550			
:	Sta Registr			32. Řegistrar's S	ignature	A	- ~ + D + + V	JUNIA	114/ 110 21330			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU 0 For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Betty Jane Wollner May 3, 2006 11:35 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Montgomery Hospice- Casey House 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Country) May 27, 1918 Washington, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F 577-16-2577 87 Director Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 TXNo Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 712 Chesapeake Avenue 20910 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 👿 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. SpecifyWhite 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Magnum Sarah Blanche Quidley 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20016 Apple lowre Circle, Gormantown, ce of Disposition (Name of netery, crematory or other place)

May 31, Paulett L. Soner/ Daughter MD 20576 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State DBurial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Arlington, Virginia 21. Signature of Funeral Service Licens Francis Address Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause () inal disease or condition resulting in death) Priysician Pneumonia /Medical Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed burial-transit attending physicien and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Tyes 2 No 3 Probably 4 X Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? this certificete hes at director, page 2 1 Yes 2 No 1 Yes 2₺ No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: $_{4} \square$ Nursing Home $_{5} \square$ Residence $_{6}$ (20ther (Specify) Hospice Hospital: ဥ 1 ☐ Yes 2√∑xNo 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical å 29b. Signature and title of ertifier (29c. License number 29d. Date signed (Month, Day, Year) D35635 May 4, 2006 15 to 30. Name and address of pers o completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D. 6001 Muncaster Mill Road, Rockville, MD 20855 31. Date filed (Month, Day, Year) MAY 0 9 32 Physistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

								d Mental Hygiei	-	10100
			1 - State Registrar		-	ertificate of		Reg.	2000	16120
2		Щ	1. Decedent's Name (First, Middle, La	ist)				2. Date of Death		3. Time of Death
	Physici /Medi Examir	cal	Robert Patton W: 4a. Facility Name (If not institution, give			4b. City, Town,	or Location of D	Illay 7	4c. County of Dea	6 6.09 PM
			Doctors Communit	y Hospita	1	Lanhar	1]	Prince G	eorge's
	uneral			Sex 7. Ag 1⊠M 2□F	e (In yrs. last birthda	Months Days		lin. 8. Date of Birth (Month, Day, Yei	ar) 9. Bi	irthplace (State or Foreign Country)
	rector		577-22-3066 Usual Residence of Decedent		93 ***			Jan.7,1913	} Was	hington,DC
yland	at at		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
e Mar	a-f si	ctor	Maryland Prince (George's	Mitchell	lville				1 ☐ Yes 2 🙀 No
/ith th	or 28	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	Country?
eath v	19 23e		10450 Lottsford I		Survivil C 4	207		(0	USA	
fter de	financia financia	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces?		If Yes, specify Cub	nispanic Origin? San, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - Am Black, Wh	
036 ours a	Pari, o	by	3 ₩idowed 4 Divorced	1 ☑ Yes 2 ☐ I If Yes, Give Year or Dates:	WWII	1 ☐ Yes 2X No	Specify:		Specify:	ite
:1215-0036 // within 72 hours after death with the Maryland ene.	natur	Completed	15. Decedent's E (Specify only highest gr			cedent's Usual Occu ve kind of work done		working 16b.	Kind of Business	
Athin of the second	han B Ma	mpi	Elementary/Secondary (0-12)	College (1-4or 5	5+)	DO NOT use retire	ed)			
filed v	marked other than "natural", or Iteme 23a or 28a-f show imailc event. It a Modical Examinar must be nutified at		17. Father's Name (First, Middle, Last	5+	Edit	or Burea	u Chief	Fed	leral Gov	vernment
ld be	ked o	To Be	Wildurr Willing				_	, .,,,	on domaino,	
Maryland 21215-0036 Id 2 should be filed within 72 hours at the and Mental Hygiene.	s mar	-	19a. Informant's Name/Relationship	Туре, Print)	19b. Ma	tiling Address (Street	Jesse and Number or	McNair Rural Route Number, Cit	y or Town, State,	Zip Code)
	n 27 I nar tra		Cynthia W. Frazie	r Daught		Pinecres	t Drive	Greenville	NC 27	358
imore Pages 1 ment of H	To of ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dis	position (Name of rematory or other pla n Memoria	¢θ)	Date 20c.	Location - City of	r Town, State
Baltimore, permit. Pages 1 ar Department of Hea	Important: If it		4 □Donation 5 □Other (Special			Park	May	10,2006 Ro	ckville,	Maryland
Ba pem Depa	any i		21. Signature of Funeral Service Lice	10	F	rancis J.	Collin	s Funeral Ho	me, Inc.	
			23a. Part1. Enter the disease, or corr	plications that caused	the death. Do not e			vd.,W.,Silve	r Spring	Approximate
Pnys	sician		shock, or heart failure. List only Immediate Cause (Final disease or condition		iration	Pneu	mank			Onset and Death
/Me	edical		resulting in death)	d	a consequence of):					C arch
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pe	ısıt	nine	Cause (Disease or injury	Due to (or as	a consequence of):					
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riffica	attending phy I for use as th		IF FEMALE:							
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	the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time of death	i ☐ Other (specify) _			North	Day Year
Hecords, P.O. The law requires that the	been signed by the should be detached	y Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did tobacco	use contribute t	o the cause of death?
Records, he law requires t	n sigr uld be	Completed by	Diabetes M	ellitus				1 ☐ Yes	2 ₩ No 3 □ P	robably 4 Unknown
S × S	2 sho	piet			•			24a. Was an	24b. Were a	utopsy findings available completion of cause of
¥ §	ete ha page	Com						autopsy performed?	death?	completion of cause of
/Ita	certificete has t	Be	25. Was case referred to medical examiner?					eath (Check only one)		
≒ ≥	sid la	-T	1 Tes 2 No	Hospital:			4 🗆 Nursing	Home 5 Residence		ecify)
ding of	9 te	tion	1 Acural 5 Pending 2 Accident investigatio	28a. Date of Injui (Month, Da)	Year) Injury	Wo	rk? Yes 2 □No	28d. Describe how in	ury occurred	
DIVISION al or Attending s after death.	rector: After to by the funera	Certification:	3 Suicide 6 Could not b	e One Blace of Init	ury - At home, farm,			28f. Location (Street	and Number or R	ural Route Number,
ital or	rel Dig							City or Town, Sta	,	
To the Hospital	To the Funerel Dire completely filled in b	edicai	29a. Certifier (Check only one) 1 ☐ Certifying Pt 2 ☐ Medical Exar	nysicien: To the best on niner: On the basis of and manner sta	of my knowledge, de examination and/or ited.	ath occurred at the til investigation, in my o	me, date and pla ppinion, death of	ice, and due to the cause curred at the time, date a	s) and manner as nd place, and dur	s stated. e to the cause(s)
To th within	To th	Me	29b. Signature and title of certifier			29c. Licens	e number	29d. D	ate signed (Mont	th, Day, Year)
11	11		, couls	1	7	D 20	7073	V	-(8)00	
10	7 /		30. Name and address of person who		eath (Item 23a) (Typ	e, Print)	ve fle	courred at the time, date a	n md	. 20706
建筑 的	Sta	10-	31. Date filed (Month, Day, Year)		ar's Signatule	Regali)	, ,	1 /22		
F	ાટ Registr			2006	40 JG. A					

			For State Registrar	State of Maryland		rtment of He tificate of D			ene 200 (5 6 2
	Physici /Medio			ATERS				2. Date of Death Month	Day 2006	3. Time of Death
	Examir	ier	4a. Facility Name (It not institution, give st PENINGUA REGIONAL	Medicas Co	arr		usky	,	4c. County of Dea	nici
	Funeral Director		5. Social Security Number 6. Sex 222-14-9471 Usual Residence of Decedent	7. Age (In yrs. las M 2□F 79	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,) AUG 14,	1926 MA	tholace (State or Foreign ountry) RYLAND
	Maryland f ehow	ţō	10a. State 10b. County MARYLAND WORCESTE		Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 🏋 No
	death with the Marylan sms 23a or 28a-f ehow ir must be notified at	ai Directo	10e. Street and Number 9719 HOTEL ROAD		101101	10f. Zip Code 21813		109	g. Citizen of What Co	puntry?
036	urs after al', or tte	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	i	Vas Decedent of His Yes, specify Cuban ☐ Yes 2X No	panic Origin? (Spe , Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: BI	e, etc.
9500-51212	within 72 ene. than "nat	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	College (1.40r 5+)	(Give k life. D	ent's Usual Occupat kind of work done du IO NOT use retired) OR TRAILER	iring most of workir	16	Bb. Kind of Business POULTRY	/Industry
/land /	should be filed nd Mental Hygi marked other amatic event, I	To Be C	17. Father's Name (First, Middle, Last) MORRIS EDGAR WATER	S			18. Mother's Name JOSEPHI	(First, Middle, Ma	,	
e, Marylan	s 1 and 2 sho of Health and I ltern 27 is mu other traum		19a. Informant's Name/Relationship (Type FLORINE E • WATERS /	WIFE	9719	HOTEL ROA	AD, BISHO	PVILLE,	City or Town, State, .	21813
Baltimore,	permit. Pages 1 Department of H Important: If Its eny injury or ot		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	ST.	JOHN'	sition (Name of atory or other place) S CEMETER	Y 5/13/		ILLSBORO,	DELAWARE
n n	permi Depa Impo eny ii		21. Signature of Funeral Service Licensee	Elson	WA MI	Trended.	ERAL HOME DELAWARE	19966	SHINGTON	ST.,
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to (or as a consequence)	nce of):	<i>×</i>				Interval Between Onset and Death
08/00,	ficate be executed physician and is the burial-transit	edicai Examin	Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequen	and	en E	mla	li _		
C. Box 6	death certif e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of deal 9 □ Unknown	leath 3 □	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
ras, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions control	nbuting to death but not resulting	ing in the und	derlying cause given	in Part I.		cco use contribute to	the cause of death?
Vital Records,	The far ate has page 2	Completed						24a. Was an autopsy performe	prior to	atopsy findings available completion of cause of 2 No
Son of Vit	ding Phys	ertification; To Be	27. Manner of Death Natural 5 Pending 2 Accident investigation	spital: 1 X Inpatient 2 DEF 28a. Date of Injury (Month, Day Year)	R/Outpatient 8b. Time of Injury	3□ DOA Other 28c. Injury a Work?	4 LI WUISING HOI		ce 6 Other (Special Injury occurred	offy)
DIVISION	Hospital or Attent A hours after death Funeral Director: etely filled in by the	O	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)				City or Town, S		
	To the Hosp within 24 hou To the Fune completely fi	Medical	29a. Certifier Check only one) Certifying Physic Check only 2 Medical Examine 29b. Signature and title of certifier	cian: To the best of my knowle Pr: On the basis of examination and manner stated.	n and/or inve	estigation, in my opin	nion, death occurre	d at the time, date	and place, and due	to the cause(s)
	⊢ ≱ F 8		30. Name and artifles of person who com	plet cause of dear (Item 2	13a) (Tune D	A00.	574/	0 5	19/0	6
В.	A. 6 Sta	te	Dr. Simona Eng.	100 Carroll 32. Registrar's Signatur	57.	Salisa	oug N	al 7/8	04	
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		1	For State Registrar	State of Mary		artment of rtificate o		and Mental I	Hygien	- Z II II I	6 16122
7			1. Decedent's Name (First, Middle, La	st)				2. Date of Month		ay Year	3. Time of Death
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)	Examin		4a. Facility Name (If not institution, giv				, or Location of	f Death /	40	c. County of Dea	ath
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	Funeral		Social Security Number 6. S		yrs. last birthday)	If Under 1 Yes Months Day		Min. (Month	n, Day, Year) (rthplace (State or Foreign ountry)
	Director		216-22-7345	XM 2□F	78 Yrs.			6-	14-2	7	MD
	pu 🛊		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation		-			10d. Inside City Limits
	aryla eho	2		7	V						1 √ Yes 2 □ No
	28a-f	Director	WV Miner 10e. Street and Number	aı	Keyser	10f. Zip Code	Α		10g. C	itizen of What C	country?
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	eath se 23	Funerai	1380 Ludwick S	12. Was Decedent Ever	r in U.S. 13.	267 Was Decedent of	of Hispanic Orio	gin? (Specify Yes o	or No-	14. Race - Am	erican Indian,
	ltern	nu	11. Marital Slatus 1 ☐ Never Married 2 ☑ Married	Armed Forces?		If Yes, specify C	uban, Mexican	, Puèrto Rican, etc	c.)	Black, Wh	ite, etc.
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215-0036	2 hou	ed	15. Decedent's E	ducation	16a Dece	dent's Usual Oc	cupation	t of working	16b.	Kind of Business	s/Industry
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	il Hygi other	0	17. Father's Name (First, Middle, Last	_			18. Mothe	r's Name (First, Mi	iddle, Maide	n Sumame)	
<u>a</u>	Mental I	To B	Robert L. Wa	lker Sr.			Nac	omi Bru	mback		
Maryland	S E E		19a. Informant's Name/Relationship		19b. Maili	ing Address (Stre	eet and Numbe	er or Rural Route N			
ž	1 and 2 Health a tem 27 le		Joanna Walker	wife	1380) Ludwi	ck St	. Keyse	r, WV	7. 2672	26
ē,	of Hea		20a. Method of Disposition	ŧ	20b. Place of Disponentery, cre	osition (Name of	place)	Date	20c. l	Location - City o	r Town, State
Ę	Page ent c nt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Potomac	Mem.	Garde	ns 5-15	-06 F	kevser.	. WV
Baltimore,	permit. Pages Depertment of Important: If I eny Injury or c		21. Signature of Funeral Service Live	nsee 777	2	2. Name and Ad	dress of Facilit	ty			
ã	permit. Depertition of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control o		William Hotel	le de				ral Hom			ST.
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the one cause on each line.					ony arrest,	-, WV 2	Approximate Interval Between Onset and Death
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н	Examiner		Sequentially list conditions,	b. Core	MARY	MITE	504	NIDE HS	E		ころかくろうべ
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ord	v requir been s should	ted	SUS ONNER !	N. S.	,1190				-		
Records,	aw 2 st	Completed	HYPOTHYRON	M. SW					Was an autopsy	24b. Were a	autopsy findings available completion of cause of
<u>ж</u>	Thate are	no.	HIPERLIDIC	<i>emia</i>				101	performed? Yes 2/11		s 2 No
ita	ysicien: The is certificate director, pag	Be (25. Was case referred to medical examiner?					e of Death (Check	only one)		
of Vital	S S D	2	1 Yes 2 →No	Hospital: 1 Anpatient	2 ER/Outpatie			ursing Home 5			pecify)
0		ü	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time Injury		Injury at Work?		cribe how in	jury occurred	
Division	ttending death. ctor: After y the fune	ati	2 ☐ Accident investigation			М	1 Yes 2				
Σ	er de	₽	3 Suicide 6 Could not determine			treet, factory, off	lice		tion (Street a or Town, Sta		Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:									
	hou hou	cai	29a. Certifier 1 Certifying F	hysician: To the best of r	ny knowledge, dea camination and/or i	ith occurred at the investigation, in r	ne time, date ar my opinion, dea	nd place, and due t ath occurred at the	o the cause time, date a	(s) and manner and de-	as stated. ue to the cause(s)
	the hain 24 the F	Medicai	one)	and manner stated							
	With To 1	2	29b. Signature and title of pertifier	120	\neg	29c. Li	cense number	つニ	290. L	Date signed (Mo	Thin, Day, Tear)
			Kuser	1	Ó	1	7218	10	1 41	174 11	2000
6	111/0		30. Name and address of person wh	completed cause of deat	th (Item 23a) (Type	e, Print)		0. /	2 (1 011	015.3
4	TVH		DR. Kobert	velity 40	od Jet	ON DA	rive	LCUMBE	Rlan	d WD	1,21502
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	1 0					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** 7:42 Ам 2006 May 11, Willard Reed Wilt /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Grantsville Garrett 187 Smith Rd. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 12,1940 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sax **Funeral** 1 XM 2 7 F 65 Maryland Director 212-38-6187 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-f show the Medical Eventicer must be notified at 1 Yes 2XNo Director Grantsville MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21536 USA 187 Smith Rd. death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ 3 ₩ Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Fire Brick Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygient Important: If item 27 Is marked other the any injury or other traumatic event, Ital. 2006. Maintenance Manufacture 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gladys Palmer Ray Wilt 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 187 Smith Rd., Grantsville, MD Ray J. Wilt/Son 21536 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Grantsville Cemetery May 15,2006 Grantsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) codear Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit requires that the death certificate be executed 25010 Due to (by as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Tilnknown signed 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 2 □ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b Time of 28d. Describe how injury occurred Certification: After or Attending s after death.
I Diractor: Afte d in by the fune 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funaral I To the Hospital 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

Robin Bissell, 124 Miller St., Grantsville, MD

31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 16 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

29c. License number

D00 34

29d. Date signed (Month, Day, Year)

May 12, 2006

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Florence Bertha White April 28, 2006 3:15 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett County Memorial Hospital Oakland Garrett If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. (Month, Day, Year)
Mar. 29, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Director 214-52-1476 87 1919 West Virginia Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location rthan "natural", or iteme 23a or 28a-f ehow the Modical Expendible in ust be notified at 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 674 Crellin Mine Road 21550 USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. o filed within 72 hours after Il Hygiene. other than "natural", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White þ Specify. 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: If item 27 is marked other tt
any injury or other traumatic event, IIIs
ance. 6th Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amos Moats ၀ Martha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger White/ Son 488 Crellin Mine Road, Oakland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Aurora Cemetery 5/1/2006 4 ☐ Donation 5 ☐ Other (Specify) Aurora. WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 32 S. Second St. Stewart Funeral Home Oakland, Maryland 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Infarcted Bowel and embulism to LLE Days /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hours Due to (or as a consequence of) Examine use as the burial-transit that the death certificate be executed and Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 🗓 No Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Age, Metabolic Acidosis, Possible Stroke 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 🛣 No certificate 1 ☐ Yes 2 ☐ No Division of Vital : After this certifica e funeral director, p Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2X No 1 X Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospitel or Attending 5 Pending investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 3 Suicide 6 Could not be determined within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061570 4/28/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. David J. Paolini, MD 317 Pythian Ave., Oakland, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAY

2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** May 03, 2006 10:00 A M Glenwood Earl Winters, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14601 Upper Georges Creek RD Midland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 MM 2□F Maryland Director 220-38-0267 January 09, 1942 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Midland Maryland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 21542 **USA** 14601 Upper Georges Creek RD Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. int: If Item 27 is markad other than "natural", or Items 23 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Auto body repairman Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Margaret Pearl (Ternent) Glenwood Earl Winters, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14601 Upper Georges Creek RD, Midland, MD 21542 Kenneth M. Hopkins/brother othar 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 04. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Cumberland Crematory Cumberland, MD 21502 2006 *4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home, PA 21. Signature of Funeral Service Licensee wa E. 8 E. Main St., Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, rion as ridiac or respiratory arrest, shock, or heart failure. List only one cause on any line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician omost resulting in death) /Medical Due to (or as a consequen a of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown Part Other significant conditions 23e. Did tobacco use contribute to the cause of death? cont ibuting to death but not resulting in the underlying cause given in Part I. Be Completed by 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 2□ No 1 Yes 2/2 1 Yes 25. Was case reterred to medican examiner? Rejentsect 17 Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Natural 28d. Describe how injury occurred After 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Diractor: / ☐ Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funeral C Hospital 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Welik 704 Seton Driv 32. Registrar's Signature 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** ELSIE CYLC WHITE 11:45 AM 2006 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MICIMICO SAUSAN PENNSULA REGIONAL MEDICAL If Under 1 Year If Order 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Delaware 68 1 M XX 214-36-5158 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Hygiene. other then "neturel", or iteme 23s or 28s-f ehow ent, the Mucical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director Stockton Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21864 5719 George Island Landing Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mentel Jennie Kryworski John Cylc 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2615 Pine Ridge Ct., Pocomoke, MD 21851 Robert White/ Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a, Method of Disposition tyD Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stockton Memory 5/8/2006 Stockton, MD Depertment of Important: if eny injury or once. Gardens 22. Name and Address of Facility 21. Signature of Fundral Service Licenses Holloway Melson Funeral Home, P.A., 103 Linden Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nomino son como **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Anatural Z ☐ Accident 28d. Describe how injury occurred 28b. Time of After 5 Pending t ☐ Yes 2 ☐ No death. investigation in by the Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 20507 ed cause of death (Item 23a) (Type, Print) 30. Name and address of person y 145 E. CARROLL ST SAUSBURY 31. Date filed (Month, Day, Year) State MAY 0 9 Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylar		artment of H			giene	06	161	27
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ıth		3. Time o	of Death
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2	id 2 Ith ar 27 is trau	Ì	Pamela N. Dion (Si	ster)	11550	SE 58t	h . PI N	Morriston	Flor	rida 32	668	
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g	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Medial Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any interpretation to the traumatic event, the Marical Examination and be invitilled at once.			Charles -				Home & Cr	emator	ium P	Α.	
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DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	4 Homicide determined	28e. Place of Injury - At the building, etc. (Special Control of the building) building.	nome, larm, str ify)	eet, factory, office		28f. Location (S City or Tow	treet and Nu n, State)	imber or Rura	l Route Nun	nber,
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			30. Name and a dress of person who cor									
			Dr.Carl I. Margo			cville Pi	ke, Rock	cville, M	d. 208	352		
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9100 PM 2006 Ralph Downie Young /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sax **Funeral** Months Days Hours 1 XM 2 ☐ F Maryland Director Dec. 13, 1917 215-18-0502 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location filed within 72 hours after deeth with the Maryland 10a State 10b. County or Iteme 23a or 28a-f show other treumatic event, the Medical Examiner rount be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Germantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20874 19125 Mateny Hill Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 □ Divorced White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) U.S. Government College (1-4or 5+) Technician 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be firment of Health and Mental Hism 27 is marked other Luther Dounie Young Ruth Madora Riggs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3614 Morrison Street, N.W., Ruth Joel - Daughter Washington D.C. 20015 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 0 permit. Page Department o Important: If eny Injury or once. May 8, 2006 Damascus, Maryland Damascus Cemetery 4 □ Dopation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Molesworth—Williams P.A., Funeral Home Forest 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia Days **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto for as a provincianna of: Examiner physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy for u Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but pot resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificete 1 Yes To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 28b. Time of Injury 28c. Injury at Work? Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Feath Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Conffice Medica (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature/apd title of certified 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd Rockville Md 20850 15225 SHADY (ST ALAN CHANALES 31. Date filed (Mon AY. YO')9 2006 32. Prigistrar's Signature State en & port Registrar

ORIGINAL

		For State Registrar	State	of Maryla			nt of H			1ental Hy	giene ₂	006	15129	
Dhusia		1. Decedent's Name (First, Mide	die, Last)							2. Date of De	ath Day	Year	3. Time of Death	
Physic /Medi		Yuan	-Chao Yai	ng						May	4,	2006	11:55 P.M	
Exami		4a. Facility Name (If not instituti	on, give street and n	um <i>ber)</i>		4b. Ci	y, Town, or	Location	of Death		4c. County of Death			
		8820 Tuckerman					otoma			Montgon			ery	
Funeral Director		5. Social Security Number 216-82-0158	6. Sex 1 2 M 2 ☐ F		s. last birthday)	Month	ler 1 Year s Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da August		Col	hplace (State or Foreign untry) na	
pur 🛦		Usual Residence of Decedent 10a. State 10b. Count	N	10c (City, Town or Lo	cation						T	10d. Inside City Limits	
72 hours after deeth with the Maryland natural', or iteme 23a or 28a-1 ehow dical Examiner must be motified at	5		•	100.0									1 ☐ Yes 2 ☒ No	
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10 23	era	8820 Tuckerman		cedent Ever in	IIS 13	Was Do	20854		igin? (Sp	ecify Yes or No		ed Sta		
permit. Tugor learner and Mental Hygiene. Important: If then 27 is marked other then "natural; or theme 23a or 28a-1 show eny injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	Armed F urried 1 ☐ Yes If Yes G	orces? 2 XNo ive		If Yes, sp	2 🔀 No	n, Mexicar	i, Puerto	Rican, etc.)		Black, White	e, etc.	
atura Gallaria	ed	15. Decede	ent's Education		16a. Dece	dent's Us	sual Occupa	ation			16b. Kind o	AS of Business/I	ilan	
u de	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed		(Give	kind of v DO NOT	vork done d use retired	<i>luring</i> mos)	t of work	ing			,	
a r	E	Elementary/Secondary (0-12)	4	(1-4or 5+)		Capt.	ain				0 i 1	Tanke	r	
othe of the	Bec	17. Father's Name (First, Middle	, Last)					18. Mothe	er's Name	e (First, Middle,	Maiden Sur	name)		
Aenta rkad tlc e	To E	Ming-S	Shih Yang							Fan-Yu	Hsi	eh		
and a		19a. Informant's Name/Relation			19b. Maili	ng Addre	ss (Street a	and Numbe	er or Rura	al Route Numbe	er, City or To	wn, State, Z	ip Code)	
alth a		Ying-Nan Yan	/Wife		8820	Fuck	erman	Lane	, Po	tomac,	Mary1	and 20	854	
A to the		20a. Method of Disposition 1 ☐ Burial 2 ※ Cremation 4 ☐ Donation 5 ☐ Other (State	Place of Dispo	natory o	other plac	1		Pate 2006		on - City or T		
ortan ortan Injury			170	Me									Virginia	
Dep imp		21. Signature of Funeral Service Lipensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20												
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ysician Medical kaminer		shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a. Meta	static (or as a conse		Canc	er						Interval Between Onset and Death 1 1/2 Years	
sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	U	etes Me (or as a conse									30 Years	
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by the attending tached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	1 Live	utcome of pregrebirth 2 Perinant at time of nown	tal death 3[Ectopic Other (pregnancy s <i>pecify)</i>				23d.	Date of delive Month	very Day Year	
gned be de	by	Part II. Other significant condit	tions contributing to	death but not re	esulting in the u	nderlying	cause give	n in Part I.					the cause of death?	
been s	ted									101	es 2UN	3 Pio	bably 4 🖄 Unknown	
has Je 2	Completed											b. Were autoprior to codeath?	topsy findings available ompletion of cause of	
this certificate al director, peç	Be	25. Was case referred to medic examiner?	-						of Death	(Check only o	ne)			
this or	ဥ	1 ☐ Yes 2 ☒ No			☐ ER/Outpatier	t 3 🗆 E	Othe Othe	0. 4 □ Nu	rsing Ho	me 5 🖾 Resid	lence 6 🗆	Other (Speci	ify)	
h. After t funera	ü	27. Manner of Death 1 Natural 5 Pend	ing 28a. Date	of Injury oth, Day Year)	28b. Time of Injury		28c. Injury Work	at ?		28d. Describe h	ow injury oc	curred		
or: A	cati		tigation			М		/es 2 □ I	No					
s affer o	Certification;	4 Homicide deter	mined 286. Place	e of Injury - At l ling, etc. <i>(Spe</i> c	home, farm, str cify)	eet, facto	ory, office			28f. Location (S City or Tow	itreet and Nu n, State)	ımber or Rur	ral Route Number,	
within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	29a. Certifier 1X Certify (Check only 2 Medical	ing Physician: To th Il Examiner: On the t and mar	e best of my kr pasis of examinated.	nowledge, death nation and/or in	occurre estigation	d at the tim	e, date an inion, dea	d place, a	and due to the ded at the time, d	cause(s) and date and plac	manner as s ce, and due t	stated. to the cause(s)	
withir To th comp	Σ	29b. Signature and title of certifi	er			2	9c. License	number			29d. Date siç	ned (Month,	Day, Year)	
3		If dv:	- Cha	JMD			D 3	34969			May 5,	2006		
		30. Name and address of person H. Victor Chian	·			,	or Dr	ivo	#220	Pooles	rf11a	MD 2	0850	
-64	te.	31. Date filed (Month, Day, Yea.	-	9/0/ Megistrar's Sign		Jeill.	CL DE	1,46,	11 220	, AUCKV	TTTE,	rω. 2	.0000	
Sta Regist		40.044	9 2006	and and a	K. A	BALL								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Year 2006 May 2, Alice Marion Young 5:51 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Hospital Cheverly

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year North, Day, Year Dec. 2, 1 Cheverly Prince Georges 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 79 Director 579-30-5542 1926 Washington, D.C. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits tame 23a or 28a-f show the Medical Examiner must be notified at 1 yes 2 □ No Director Maryland Prince George Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20715 16010 Excalibur Road United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 🛣 No Specify: Š Specify: 3 Widowed 4 Divorced Black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Means, pings. Elementary/Secondary (0·12) 12th College (1-4or 5+) Child Care Provider Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marion Levi Elizabeth Levi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16010 Excalibur Road Bowie, Maryland 20715 Melvin L. Young / Spouse 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Cem. 5/8/06 Landover, Maryland 21. Signature of Funeral Service Licenses Alexander sport Frome Funeral Homes, P.A. 01 00 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part I Enfer the disease, of complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ORONARY /Medical Examiner Ratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregpant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 2 🗆 No 1 ☐ Yes 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3□ DOA this 27. Manne of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation nere! Director: , filled in by the f 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Temping Priyactan. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and Atle of certifier 29d. Date signed (Month, Day, Year) 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd., Cheverly, MD 20785 Landover 32. Registrar's Signature 31. Date filed (Month, bay, Year) State MAY 0 8 2006 Registrar

		-	For State Registrar		aryland / Dep <i>Ce</i>	ertificate of		Re	g. No.	1513			
	Physicia /Medic		1. Decedent's Name (First, Middle, Las Houard		Lachn	nann		2. Date of Death Month May	Day Zear	3. Time of Death SO PM			
	Examin Funeral Director		4a. Facility Name (If not institution, give Howard County Gen 5. Social Security Number 6. St 135-03-8334	eral Hospi	ital e (In yrs. last birthday 89 Yrs.	Columb	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 13	Year)	thplace (State or Foreign			
	ט	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation		march 13	,191/	10d. Inside City Limits			
	n with the Ma 3e or 28a-f	al Director	Md. Howard 10e. Street and Number 8320 Church La	ne Rd.	Ell	10f. Zip Code	•	10	g. Citizen of What C				
36	init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hygiene. crent: If item 27 is marked other than "naturel", or items 23e or 28a-f show injury or other treumatic event, I'm Medical Exercities must be notified at the	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2√2 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:				
21215-0036	within 72 hou lene. 'than "nature	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Giv	edent's Usual Occup e kind of work done o DO NOT use retired	during most of worki l)	ing 1	6b. Kind of Business State Gov	/industry			
Maryland 2	2 should be filed n and Mental Hygic is marked other reumatic event, II	To Be Co	17. Father's Name (First, Middle, Last) Ludwig Zachmani	laiden Sumame) Lehleiter	mame)								
	s 1 and 2 sho Health and tem 27 is m		19a. Informant's Name/Relationship (7) Howard R. Zachmani 20a. Method of Disposition		832 20b. Place of Disp	20 Church	Lane Rd.	Ellicott	City or Town, State, . City, Md. Oc. Location - City or	21043			
Baltimore,	perrit. Pages 1 and Dep riment of Health Imp. rtent: If item 27 any injury or other tr gnce.		1 Surial 2 Cremation 3 C 4 Donation 5 Other (Specify 21. Signature of Fineral Service Lion)	Good Sher	22. Name and Addres	etery 5/8/	y H.Witz	llicott Ci zke's Fami	ly F.H.Inc.			
	Pnysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately considered the death of the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, rrest, and the mode of dying arrest, and the mode of dying arrest, and the mode of										
	/Medical Examiner	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of): LCK Sir a consequence of,.	ius S	Lngeon	me		Zo years			
68760,	ficate be executed physician and is the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence of):								
.O. Box 6	death certiff e attending od for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy			23d. Date of de Month	livery Day Year			
S, D	w requires that the s been signed by th should be detache	by	Part II. Other significant conditions of		ut not resulting in the		en in Part I.	23e. Did toba		o the cause of death?			
Vital Record	The law ate has b page 2 s	e Completed	25. Was case referred to medical				26. Place of Death		ed? prior to death? No 1 □ Yes	utopsy findings available completion of cause of			
of	Phys this ral dii	on; To B	examiner? 1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	ry 28b. Time		er: 4 Nursing Hor		nce 6 Other (Spe	cify)			
Division	I or Attending I after death. Director: After I in by the funer	Certificatio	1 KNatural 5 Pending investigation 3 Suicide 6 Could not be determined		ury - At home, farm, s	M 1 🗆	Yes 2 □No	28f. Location (Stre City or Town,	eet and Number or Ro State)	ural Route Number,			
	o the Hospitel or Atten ithin 24 hours after deat o the Funerel Director: ompletely filled in by the	edical			of my knowledge, dea f examination and/or i ated.								
ri.	To the within To the comple	Σ	29b. Signature and title of certifier 30. Name and address of person who	Q J K	eath (Item 23a) (Type	29c. Licenso	360 \			,2006			
15	Sta Registr	-	11065 C+FF/C 31. Date filed (Month, Day, Year) MAY 0 9 2	Pature	ar's Signature	/ . /	umbra	MS	21044	ک			

Please Type or Print in Black Indelible Ink Dorothy M Anderson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Death Month Day May 17, 2006 Dorothy Μ. Anderson Medical Examine 2026 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Saint Joseph Medical Center Towson **Baltimore County** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** oreign Months Days Hours Director 220-34-5482 1 M 2 X F Country) 67 June 17, 1938 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f shov MD Baltimore Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
rijury or other traumalic event, the Medical Examiner must be notified at once. Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 2315 Westchester Avenue 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funera 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black Armed Forces' Never Married 2 X Married White, etc. Yes Widowed Divorced If Yes, Give Year Yes 2 X No specify: Specify: White þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Ballard Ashley Clara Pearl Manis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Walter Ray Anderson (Spouse) 2315 Westchester Ave. Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Crestlawn Mem. Garden's 5/22/2006 Marriottsville, MD Donation 5 Other Specify. 21. Signature of Funeral Service Lizenses PANCE AND ADDRESS OF SOLUTION OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF T 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause or each line Between Onset and /Medical Death Complications of hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED **AMENDED** item#23a,27.perME.g858,8/29/06 TT Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 V No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed s been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page 1 🗸 Yes ✓ Yes 2 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ DOA Inpatient FR/Outpatient 3 2 Nursing Home 5 Residence 6 Other: Scene 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗸 Natural 5 Pending Yes 2 No Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined within 24 hours a 29a Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 18, 2006 Name and address of person who completed cause of death (Tem 23a) Theodore King MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)

State Registra

Certificate of Death

2. Date of Death

Mai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

2350

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Yes 2X No

9. Birthplace (State or Foreign

Maryland

Race - American Indian, Black, White, etc.

Specify: White

Month

214176435 Y16106 May 19, 2006

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Year

2006

N/A

Physician /Medical 1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

harles

State Registrar DHMH 17 Rev 1/2001 Hamid

31. Date filed (Month,

14200 MAY 2 3 2006 South

32 Aegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death May 20, 200<u>6</u> **Physician** 9:10 A M William Henry Burgemeister /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner Baltimore 9401 Wordsworth Way Owings Mills If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year Feb. 28, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Sex ¥□M 2□F **Funeral** Yrs 83 Feb. 215-16-9505 1923 Maryland Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural" ~ " and properties of the traumatic events." 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 Yes 2 No Be Completed by Funeral Director Baltimore Owings Mills 10e. Street and Number 10g. Citizen of Whal Country? 10f, Zip Code USA 9401 Wordsworth Way 21117 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced white white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Burgemeister Barbara Grape 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paricia Ann Burgemeister - wife 9401 Wordsworth Way Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Cem. May 24, 06 Sykesville, MD 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21. Signalure Funeral Service Lig 301 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1) secre **Physician** Alghenners 5415 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to min ediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Medical Certification; To Be Completed by Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decadent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 200 No 1 Yes 1 ☐ Yes 2 🗹 No After this certification funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 W No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending s after death.
I Director: Aft
id in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Hospital 29a. Certifier 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Walten

Ross

31. Date filed (Month, Day, Year) MAY 2 3

1 Cely

4801

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1) or sey

May 22, 2006

Cilicott City.

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		,	1 → For State Registrar	State of Maryland		ent of Health and		ene2006	16135
	Physici /Medic	al	Decedent's Name (First, Middle, Last	nma Lee	Brocks	Sy, Town, or Location of Dea	2. Date of Death Month MAY	Day Year 21, 2006	
	Examin Funeral Director	er	5. Social Security Number 6. Se 218-3 2-7096	Medical Cent	er	Tows	8. Date of Birth	Balt 9. Birth	imore place (State or Foreign
	he Maryland 18a-f ehow	ector	3.0	rimore Co.	Town or Location	Ile, Md.	100	;. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	n 72 hours after death with the Maryland "neturel", or Iteme 23a or 28a-f ehow calcal Expoliter ouat be notified at	Funeral Director	10e. Street and Number 2 Lemon Gro 11. Marital Status	ve C+ #F 12. Was Decedent Ever in U.S Armed Forces?		21030 cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue		USA 14. Race - Ameri Black, White	ican Indian,
21215-0036	n.	by	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edi (Specify only highest grace)	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Ication Ice completed)	16a. Decedent's U	2 No Specify: sual Occupation work done during most of we	orking 16	Specify: BI	d
	be filed within tal Hygiene. Let other than "event, the Max	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Teac	18. Mother's Na	ame (First, Middle, Ma	Public Siden Sumame)	Bencols
e, Maryland	s 1 and 2 should i Health and Mer item 27 is marke other traumatic	To	19a. Informant's Name/Relationship (7) Molissa 2; 20a. Method of Disposition	Wiessner	19b. Mailing Addre		ural Route Number, Co	City or Town, State, Zi	Le Md 21030
Baltimore,	permit. Pages. Department of It important: If ite any injury or of once.		1 Burial 2 □Cremation 3 □I 4 □Donation 5 □Other (Specify, 21. Signature of Funeral Service Licens	Removal from State	gh U.M. C	r other place)	27/06 (1 ockeysvil	le Md Veray Home
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused the death. ne cause on each line. CORONARY A		3013101	ic or respiratory arrest		Approximate Interval Between Onset and Death
	/Médical Examiner	ner	resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque CARD I DMYOP Due to (or as a conseque	YHTAY				
68260,	death certificate be executed e attending physicien and ad for use as the burial-transit	icai Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. ELECTROLYT Due to (or as a conseque HISTORY OF	ence of):				
.O. Box 68	death certific e attending p od for use as t	Physician/Med	JF FEMALE: 23b. Was decedent pregnant in the past 12 ponths? 1 □ Yes 2 DNo 9 □ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of dea 9 □ Unknown	death 3 Ectopic			23d. Date of deliv Month	ery Day Year
s, P	The law requires thet the site has been signed by the bage 2 should be detache	þ	Part II. Dther significant conditions co	ntributing to death but not result	lting in the underlyin	g cause given in Part I.	23e. Did tobac	2 No 3 Pro	the cause of death?
Vital Record		e Completed	25. Was case referred to medical			36 Place of Di	24a. Was an autopsy performe 1 Yes 2	prior to co	opsy findings available ompletion of cause of 2 No
of	ng Phys fter this neral dii	To B	avaminar? . !		28b. Time of Injury M	Other		ce 6 Other (Special injury occurred	(7)
Division	a F F E	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify))		City or Town, S		
	the Hospitel hin 24 hours the Funeral I	Medical	(Check only 2 Medical Exam	rsician: To the best of my know iner: On the basis of examination and manner stated.	on and/or investigati	on, in my opinion, death occ	urred at the time, date	and place, and due t	o the cause(s)
	To To COM	~	29b. Signature and title of certifier	(a. o m)		D 31296		. Date signed (Month,	
	\		30. Name and address of person who co			DRIVE TOWS			
410	Sta Registi		31. Date filed (Month, Day, Yest) 200	32. Registrar's Signatu	ure	V		BERRY STO SALE	-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 19, **Physician** 2006 3:00 p Gloria Jean Brunet /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Street Harford 3019 Blue House Road 8. Date of Birth Month, Day, Year) Jul. 13, 1944 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕇 F Months Days Hours 219-42-7678 Yrs Maryland Director 61 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b County 10a State 7 is marked other than "natural", or itams 23a or 28a-1 show traumatic evant, the Madical Examinating the motified at 1 ☐ Yes 🏖 ☐ No MD Harford Street Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3019 Blue House Road 21154 **USA** Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian Black, White, etc. iled within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced white white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dispatcher Police Dispatcher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ould be f Harry Stanton Wyre Marie Gladys Shenberger 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an pernit. Pages 1 and 2 Department of Health a Important: if itam 27 is any injury or other trai Danielle L. Brunet - Daughter 1750 Glen Gove Roed Darlington MD 21034

Method of Disposition (Name of Disposition (Name of Date 200. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory May 23, 06 Baltimore, MD 21. Signature of Funeral Service Lice see ²²Cremation Society of Maryland, Inc. 239 Frederick Road Baltimore
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Leukenia Pnysician 2weeks /Medical Due to (or as a consequence of) Examiner Nuntudgians Lymphoma Recorrant 4 months Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of: Examiner Therapy for Thyroid cancer 11 years be executed burial-transit Radiatur Due to (or as a consequence of) physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
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Vital o Division

Records, or Attending 24 hours a within 2 the

> Registrar DHMH 17 Rev 1/2001

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

peosley

Prashant Shukla

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2005

15 south

32. Registrar's Signature

Medical

State

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

2000 45020

Parke street Aberdeen mg 21001

29d. Date signed (Month, Day, Year)

19/06

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el W. Brow	1	St I- For State Registrar	ate of Maryla		ment of ficate of		d Mentai I		eg. No. 2	006 1613		
Physicia al Examir	in/ ner	Decedent's Name (First, Midd	Micha		ont 1	Brown		2. Date of Dea Month May 17, 2	Day Year	3. Time of Death 2105 hrs		
		4a. Facility Name (if not institution 38 Blooming Dale Ave)		mber)	4	b. City, Town, or Catsonville	Location of Dea	ath	4c. County of Baltimore			
Funeral Director		5. Social Security Number 217-62-7841	6. Sex	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days		Irs. 8. Date of Bir in. 1-17-	,	Birthplace (State or Foreign Country) Md		
th the Maryland 23a or 28a-f show any notified at once.	al Director	10e. Street and Number 38 Bloomingo		Cat	own or Locatio	1e 10f. Zip Code 2122			USA			
permit. Pages I and 2 should be filed within 12 hours after deam with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12th grade	Armed F. 1 X Yes orced If Yes, Give Yes or Dates: city only highest gran	Specify Yes or Noto Rican, etc.) If work done elired) N/A	Specify: B							
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7		30. Name and address of person Ana Rubio MD. As	sistant Medical		11 Penn S	treet, Baltimo	re, MD 212	01				

06-03185

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State of Maryland / Department of Health and Mental Hygiene

Joann Esther Bai		S - For State	tate of Marylar	•	rtment of		d Mental	-	gray gara	06 1610		
Dhysisis		Registrar 1. Decedent's Name (First, Midd	ile Last)		tincate of	Death		2. Date of Deat	eg. No.	3. Time of Death		
Physicia Medical Examir	ner	Joann		Ε.		Baile		Month May 11, 20		1206 hrs		
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Funeral		5. Social Security Number		7. Age (In yrs. Ia	ast birthday)	If Under 1 Yea	r If Under 24	Hrs. 8. Date of Birt		Birthplace (State or		
Director	- 1	216-78-6455	1 M 2√√F	4	5 Yrs.	Months Day	s Hours I	Min. 01 2	7 61	Foreign Country) MD		
		Usual Residence of Decedent			***				/ 01 1			
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yłand a-f sho	혅	MD N 10e. Street and Number	<u>A</u>	В	altimo	re 10f. Zip Code	-		0g. Citizen of Wha			
ith the Maryland 23a or 28a-f show any notified at once.	Director	2706 Baker	Street				1216		U.S.A.			
with t	<u>ra</u>	11. Marital Status	12. Was Dece	edent Ever in U.	.S. 13. Wa		panic Origin?	(Specify Yes or No-		American Indian, Black,		
death death	Funeral		Armed For 1 Yes	2X No				erto Rican, etc.)	Specify:	Black		
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72 hour	eted	Elementary/Secondary (0-12				ost of working life				ŕ		
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212 lid be Menta marke	To Be	Joseph Bail 19a. Informant's Name/Relation			19b. Mailing	Address (Stree		. Legett or Rural Route Num		State, Zip Code)		
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	1	20a. Method of Disposition 1 XBurial 2 Crematic	on 3 Removal fro		Place of Dispos crematory or oth	tion (Name of cemetery, Date place)			20c. Location - City or Town, State			
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other S	Specify:		ng Mem	orial	Randal	lstown, Md				
Balt Sermit. Departu Importury	1	2 . Signature of Euneral Service		0	l Ma	rch F/	H West					
Physician	-	3a. Part I. Enter the disease, of	or complications that ca	used the death	. Do not enter t	00 Waba ne mode of dying,	ash Av such as cardia	re, Balt ac or respiratory arm	imore, est, shock, or hear	Md 21215 Approximate Interval		
/Medical		failure. List only one caus Immediate Cause (Final diseas	C1:	arrhyth	mia assoc	iated with	n acute c	coronary art	ery thromb	Between Onset and OSia Death		
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68760 certificate I ding phys	n/Me	IF FEMALE: 23b. Was decedent pregnant in		outcome of preg		tal death 3	Ectopic pre	eanancv	23d. Date of d	elivery Day Year		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Physician/M	past 12 months?	4 Pregna	ant at time of de	a citis	her (Specify)		J ,				
Box he death c y the atten by the dfor us	hys	1 Yes 2 ✓ No 9 U Part II. Other significant cond	nknown 9 Unkno	2.4.3945.00	resulting in the	inderlying cause	niven in Part I	23e Did to	phacco use contrib	ute to the cause of death?		
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ords, w require us been si should b	Completed						. '	24a. Was		ere autopsy findings available or to completion of cause of		
tal Records cian: The law requi certificate has been ector, page 2 should	ldmo				_	_			rmed? de	ath? Yes 2 No		
al Ream: The ertification, pa	ou l	25. Was case referred to medic				26.Place	e of Death (Che					
of Vital I ing Physician: After this certifi uneral director,	To B	examiner? 1 ✓ Yes 2 No		npatient 2	ER/Outpatient				Residence 6			
n of ding Ph.	on:	27. Manner of Death 1 Natural 5 Pe	28a. Date of (Month, anding	of Injury Day,Year)	28b. Time of i	.	ıry at Work? Yes 2 No		how injury occurred			
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been six completely filled in by the funeral director, page 2 should the state of the funeral director.	Certification:	2 Accident Inv	estigation 28e Place	e of Injury - At h	nome, farm, stre	et, factory, office			Street and Number	or Rural Route Number, City		
Divis	ertif	4 Homicide de	termined (Specify)					or Town, S	State)			
Hosp 24 ho Fune etely fi		(or our or m)	Physician: To the bes									
Di To the Hospital within 24 hours a To the Funeral	Medical	2	caminer: On the basis of and manner st		and/or investiga	tion, in my opinioi		ed at the time, date				
	ž	29b. Signature and title of certi	111	~			.M.E.		29d. Date signed (Month, Day, Year) May 12, 2006			
notio		30. Name and address of person	on who completed ball	e of death (Iten	n 23a)							
Bolto	Ų į	Theodore King MD.	Assistant Medi		er 111 Pe	enn Street, Ba	altimore, Mi	O 21201				
S	tate	31. Date filed (Month, Day, Yea	r) 32. Re	egistrar's Signat	ture	I						

06-03395

Please Type or Print in Black Indelible Ink

	For State Certificate of Death	Reg. No.								
Physician/	zistrar Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year May 19, 2006 3Time of Death 1154 hrs								
dical Examiner	Jerome J. Bylebyl Facility Name (if not institution, give street and number) 4b. City, Town	n, or Location of Death 4c. County of Death								
1	606 West 38th Street Baltimor	N/A								
L WINGIGH	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Months 7. Age (In yrs. last birthday) If Under 1 Months	Foreign								
	a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits								
M Be bo	aryland N/A Baltimore	1 XX yes 2 No								
death with the Maryland or items 23a or 28a-f show any must be notified at once.	De. Street and Number 10f. Zip Co	21211 USA								
or items 23	Armod Forence If Ves specify C	of Hispanic Origin? (Specify Yes or No- uban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.								
or ite	1 Yes 2XX No	x _{No specify:} Specify: White								
ural", miner	or Dates: 15 Decedent's Education (Specify only highest grade completed) . 16a. Decedent's Usual Co.	cupation (Give kind of work done 16b. Kind of Business/Industry								
5-0036 ed within 72 hour lygiene. other than "natu he Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+) 12 College (1-4 or 5+) Professor	Johns Hopkins Medical School								
5-0036 iled within 7 Hygiene. I other than he Mose	7. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Maiden Surname)								
121; d be fil lental f arked avent, b Be	Harry J. Bylebyl 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Laura Wolicka Street and Number or Rural Route Number, City or Town, State, Zip Code)								
D 21 should land Met T is man natic ev	Sa. Informant's Name/relationship (1996)	er Avenue, Kenmore, New York 14217								
∑ 5 d d m m d d Z Z = L m m d d Z Z = L m m	Da. Method of Disposition Burial 2 XXCremation 3 Removal from State 20b. Place of Disposition (Name crematory or other place) Metro Cremator	of cemetery, Date 20c. Location - City or Town, State								
	1 Donation 5 Other Specify: 1. Signifure of Funeral Service Liter fee Burgee 3631 Fr	dress of Facility -Henss-Seitz Funeral Home, Inc. 21211 alls Road, Baltimore, Maryland								
Physician	3a. Pan Enter the disease, or complications that caused the death. Do not enter the mode of call the cause on each line.	lying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and								
Medical Sxaminer	mmediate Cause (Final disease or condition resulting in death) The final disease or condition resulting in death) The final disease or condition resulting in death) The final disease or cause of the final disease or condition resulting in death)	r Disease Death								
ner	Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause									
vecuted 1 and 1 transit										
0, e be execu ysician and burial - tra	UNPENDED AMENDED									
760, cate be physic the bur	F FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery 3 Ectopic pregnancy Month Day Year								
ox 68 ath certi attendin or use a	3b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specification of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second									
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s, P.(ires that signed d be det		24a. Was an 24b. Were autopsy findings available								
Division of Vital Records, lat or Attending Physician: The law requires as after death. "al Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed		autopsy prior to completion of cause of performed?								
Che lav		1 Yes 2 No 1 Yes 2 No								
tal R cian: T certific rector, p	23. Was case referred to medical	Place of Ceath (Check only one) A Other Other Nursing Home 5 Residence 6 ✔ Other: Scene								
F Vita	1 Yes 2 No Inpatient 2 ER/Outpatient 3 LO	A Other Nursing Home 5 Residence 6 ✔ Other: Scene c. Injury at Work? 28d. Describe how injury occurred								
After funer.	(Month. Day. Year)	1 Yes 2 No								
Sior Attender death ector: by the	2 Accident Investigation	handrad handrad								
Division o spiral or Attending tours after death. neral Director: After filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify)	6 Could not be determined (Specify)								
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To con	and manner stated.	License number 29d. Date signed (Month, Day, Year)								
	Par Chamis-tallale	O.C.M.E. May 19, 2006								
107	30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Pe	nn Street, Baltimore, MD 21201								
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	,								

			1 - For State Registrar	State of Maryland	-	rtment of I tificate of			ntal Hygien Reg. N	400	6 16140
	Physici	20	1. Decedent's Name (First, Middle, La	st)				2.	Date of Death Month D	ay Year	3. Time of Death
	/Medic		John Edgar Bancr						1 YAI	9 200	
	Examir	er	4a. Facility Neme (If not institution, giv			4b. City, Town,		ORE	4	c. County of De	ath
			SAINT AGNES 5. Social Security Number 6. S	HOSPITAL ex 7. Age (In yrs. las	e hirehala)	If Under 1 Year				1timore	City inthplace (State or Foreign
	Funeral Director			X M 2 □ F 74	Yrs.	Months Days		Min. 1	Date of Birth (Month, Day, Year -20-1932	r) 9. 0	Country)
			Usual Residence of Decedent					1	20 1732		ш
	Maryland a-f ehow	tor	MD 10a. State 10b. County Anne Aru		Town or Loc Burnie						10d. Inside City Limits 1 Yes 2 No
	or 28;	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What (Country?
	th wi	al	262 Cross Creek D	rive		21061			USA	1	
336	urs after dea al', or items Exeminer mu	by Funeral	11. Marital Status 1 Never Married 2 kMarried 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1x∃xyes 2 □ No If Yes, Give Year or Dates:	If	Vas Decedent of I Yes, specify Cub	an, Mexicar	n, Puerto Rica	/ Yes or No- an, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 ie marked other then "natural", or items 23a or 28s-f ehow or other traumatic event, the Medical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0·12)	de completed)	(Give)	ent's Usual Occu kind of work done OO NOT use retire ntant	during mos	t of working		Kind of Busines	s/Industry
Maryland 2	2 should be filed v and Mental Hygie ie marked other raumatic event, In	To Be Co	17. Father's Name (First, Middle, Last, Frederick Bancrof					er's Name (F	irst, Middle, Maide Sner	n Sumame)	
ary	shou and M mer		19a. fnformant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Stree	and Numbe	er or Rural R	oute Number, City	or Town, State,	Zip Code)
	1 and 2 Health a tem 27 ie		Mrs. Jacqueline B	ancroft/Wife 2	262 Cı	coss Cre	ek Dr.	Glen	Burnie,	MD 2106	51
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 eny injury or other tr ance.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other / Specif	Removal from State MD T	etery, crem	sition (Name of patory or other pla ans Ceme:		Date 0-24-20		ocation - City o	
Balti	permit. Page Department of Important: If eny injury or 2002.		21. Signatur of Fundal Service Licer	M01411		Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name		,	1 Secon	d Ave. rnie, M	27.55T.)
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. one cause on each line. a. CLOSTRIDI Due to (or as a consequer	JM				Spiratory arrest,		Approximate Interval Between Onset and Death 2 MONTHS
68760,	e be executed sicien and e burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequer c. Due to (or as a consequer							
P.O. Box 68	The law requires that the death centificate be executed wie hes been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnanc 1 \(\subseteq \text{Live birth} \) 2 \(\subseteq \text{Fetal de} \) 4 \(\subseteq \text{Pregnant at time of deat} \) 9 \(\subseteq \text{Unknown} \)	eath 3	Ectopic pregnand Other (specify)	у			23d. Date of do Month	elivery Day Year
	quires tha n signed lid be det		Part II. Other significant conditions of CORONARY	ontributing to death but not resulting ARTERY D		derlying cause gr	ven in Part I.				to the cause of death? Probably Unknown
of Vital Records,	The law requite hes been age 2 should	Completed by	PARKINSOI	DISM					24a. Was an autopsy performed?	death?	autopsy findings available ocompletion of cause of
ta		0	25. Was case referred to medical		-		26. Place	of Death (C	1 ☐ Yes 2054 heck only one	0 1016	S ANO
<u>></u>	d is	To B	examiner? 1 □ Yes 2 No	Hospital: Impatient 2 EF	VOutpatient	3□ DOA Ot	han	-	5 Residence	6 ☐Other (Sp	ecify)
ion o	든 등 교		27. Manner of Death 1 SNaturaf 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	8b. Time of Injury	28c. Inju Wo M 1		28d.	Describe how inju		
Division	al or Attending Is after death. It Director: After	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Pface of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office	<u>.</u>	28f.	Location (Street a City or Town, Star	nd Number or F 'e)	Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifying Pt 2 Medical Example	ysicien: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the ti estigation, in my	me, date an opinion, dea	d place, and th occurred a	due to the cause(s	s) and manner and place, and du	as stated. ue to the cause(s)
	withir To th	ž	29b. Signature and title of certifie	01		29c. Licen:			29d. D	ate signed (Mor	nth, Day, Year)
	1D		30. Name and address of person who	completed cause of death (ftem 2)	3a) (Type, F	Print)	1860			IAY 1	9,2006
	Sta	ate.	AJJAI ALVA 31. Date filed (Month, Day, Year)	900 CATON	UAI	ENVE	BA	LTIM	JORE,	MD	21229
	Pogist		MAY 9 3 2	106 6	Control of the	3.4 6 3 3					

BANCROFT, JOHN

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** :478 2006 SHARYN Ε. MAY 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HUNTER LAKE COURT UPPERCO # Under 1 Year | # Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0.7/31/1947 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 😿 F 58 Yrs. 014-38-4720 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28e-f ehow th and Mantal Hygiene. 27 is marked other than "naturel", or flems 23a or 28e-f ehov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE UPPERCO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth with it Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or items 23a or 2; empt injury or other fraumatic event, the Medical Examiting must be no once. 7 HUNTER LAKE CT. 21155 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 4YRS Elementary/Secondary (0-12) NURSE NURSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KENISON T. DORR PHYLLIS BRICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD BATTYE (HUSBAND) 7 HUNTER LAKE CT. UPPERCO, MD. 21155. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GREEN MOUNT CREMATORY05/18/06 BALTO. CITY, MD. 21. Signature of Funeral Service Licens SONS CO. W. JENKINS & SONS CO YORK RD MONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final **Physician** disease or condition resulting in death) 2 month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as IF FEMALE 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy 2 Fetaf death Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe certificete 21 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home Residence 6 Other (Specify) 217No Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this After the funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Atatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death
To the Funeral Director:
completely filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel Medical Examiner: On the basis of examination and/or investigation in my process doubt accurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tiple of certain 2006 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) PAUL CELANO M.D. 6569 N. CHARLES ST SUITE 205 TOWSON, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

				For State Registrar	State of Ma	aryland /		rtment of <i>ificate o</i>		d Mental H	ygiene Reg. No	006	16142
	10	E EAL I		Decedent's Name (First, Middle, Last	1)					2. Date of E Month	eath	V	3. Time of Death
		Physici /Medio		Andrew John	Birkhol:	Z				May 1	.8, 200	06	20:15 M
		Examir		4a. Facility Name (If not institution, give		Janet ere			, or Location of De	eath		ounty of Death	
				Upper Chesapeake			I belieb etc 1	Bel If Under 1 Ye		dre a Door of D		Harford	
		Funeral Director		5. Social Security Number 6. Se 215–42–1875	X 1. Age	e (In yrs. Iast 60	Yrs.	Months Day		irs. 8. Date of B in. (Month, I May 8,	Day, Year)	9. Birth	place (State or Foreign ntry) Vland
		V V		Usual Residence of Decedent		00				May o,	1940	Mat	утапи
		nylan show	_	10a. State 10b. County		10c. City, To	own or Loc	ation			-		10d. Inside City Limits
		death with the Maryland ms 23s or 28s-f show rmust be notified at	Director	Maryland Harford		Jop	pa			· · · · · · · · · · · · · · · · · · ·			1 ☐ Yes 2 ŽXNo
		vith th		10e. Street and Number				10f. Zip Code				on of What Cou	ntry?
		eath v	Funerai	3200 Winters Run	Road 12. Was Decedent I	Ever in I.I.S.	12 14	2108		(Casifu Vas as h	USA	l. Race - Ameri	an Indian
	10	fter d	F	11. Marital Status 1 ☐ Never Married 2 ※ Married	Amed Forces?		IS. VV	Yes, specify C	uban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	10-	Black, White,	
	936	al', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	□Yes 21X1N	lo Specify:		S	pecify: W	nite
, _	5-0036	filed within 72 hours atter Hygiene. ither than "natural", or Ite ont, the Medical Examine	Completed	15. Decedent's Edu (Specify only highest grad	ucation le completed)	11	(Give k	ent's Usual Occind of work do	ne during most of v	workina	16b. Kind	d of Business/In	
5	2121	Aithin ne.	npi m	Elementary/Secondary (0-12)	College (1-4or 5		lite. Di	O NOT use ret	ired)	g			
0	2	iled w Hygiei ther ti		17. Father's Name (First, Middle, Last)	1		Auto 1	Mechani	1	Name (First, Middi		omotive	Repair
7	and	d be f antal h	Be C		Birkholz				Berth		Napo		
	Maryland	should Me Me mark	၉	19a. Informant's Name/Relationship (7)		1	19b. Mailing	Address (Stre		Rural Route Num			Code)
0		permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28e-4 show any injury or other traumatic event, the Madical Examinational Examination at ODGs.											
20/811	Baltimore,	s 1 a of Hee Item		Andrea M. Birkho 20a. Method of Disposition	LZ- Daugin	20b. Place	of Disposi	tion (Name of atory or other p	lace)	Date	20c. Loca	ation - City or To	own, State
-	Ē	Page nent c ant: If ury or		1 ☐ Burial 2 To Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		-	erv. Co	,	22/2006	Towso	on, Mary	yland
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5	8	20 = 29		xxxxx alm	very				_	ad, Abin	-	Maryla	nd 21009
5.75				23a. Parti. Enter the disease, or comp shock, or heart failure. List only o	lications that caused ne cause on each lin	10.							Approximate Interval Between
	а	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Acu			card	ial I	n fares	100		S minutes
9	4	/Medical Examiner		resulting in dealiny	Due to (or as	a consequent	ce of):					1	
39			-e	S * quentially list conditions, if any, leading to immediate	b to (or as a	a consequent	ce of):						V
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Ce	ó	exec an an	Exa	resulting in death) Last	Due to (or as a	a consequenc	ce of):						
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0	89)	entifica ing ph e as th	Med	IF FEMALE:									
5	9	eath certifi attending for use as	hysician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal dea	ath 3□E	ctopic pregnar			23	d. Date of delive	ery Day Year
	0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time of death	1 5□(Other (specify)				WOTH	Day Tour
3	٦.	res that the de igned by the a be detached	a	Part II. Other significant conditions co	ntributing to death bu	at not resulting	g in the und	lerlying cause	given in Part I.	23e. Did	tobacco use	contribute to the	ne cause of death?
2	ds	uires sign	d by									No 3 ☐ Prob	
7	cords	w require s been si should t	ompieted							24a. Wa	s an	24b. Were auto	psy findings available
-	Re	9 4 9	Ë							- auto	ormed?	death?	mpletion of cause of
1	ita	sician: Th certificete rector, pag	BeC	25. Was case referred to medical					26. Place of D	Death (Check only	2 ZNO	1 ☐ Yes	2□ No
~1	. >	Jing Physician: After this certifica funeral director.	2	examiner? 1 □ Yes 2 X No	Hospital: 1 🔲 Inpatie	nt 2 ER/	Outpatient	3□ DOA	other: 4 Nursing	gHome 5□Res	idence 6 []Other (Specif	y)
17	פֿם		ation:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	y Year) 28t	b. Time of Injury	28c. In W		28d. Describe	how injury	occurred	
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BirKho		• Hospitel or Attending 24 hours after death. • Funerel Director: After etely filled in by the fune	0	29a. Certifier 1X Certifying Phy	sician: To the best of	f my knowler	dge, death	occurred at the	time, date and pla	ice, and due to the	Calleb(e)	nd manner se s	tated
9		To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edica	(Check only 2 Medical Examinations)	ner: On the basis of and manner sta	examination	and/or inve	stigation, in my	opinion, death of	curred at the time	, date and pl	ace, and due to	the cause(s)
_		To the within 2 To the complex	¥ E	29b. Signature and title of certifier	1				nse number			signed (Month,	
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			13	30. Name and address of person who co			a) (Type, P	rint)	H 1	R	11	- M	2006 d. 21014
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				1 - For State Registrar		State	of Maryla		artmen ertificat			Mental Hy	gien Reg. N	En U)6	16143		
				Decedent's Name (First, Middle)	lle, Last	1)						2. Date of De	aath			3. Time of Death		
_		Physici /Medio		David Edward B	code	. Sr.						May 16	_	006	Year	2:54 P M		
		Examir		4a. Facility Name (If not institution			ımber)		4b. City,	Town, or L	ocation of Deat			c. County	of Death			
				Upper Chesapeal	ce M	Medical	Cente	r	Bel				I	Harford				
	4	Funeral		5. Social Security Number	6. Se	x ZM 2□F		s. last birthday) If Under Months	1 Year Days	If Under 24 Hrs Hours Min.		rth ay, Yea.	r)	Birthp Cour	place (State or Foreign htry)		
	gasi	Director		217-46-0322 Usual Residence of Decedent			59	Yrs.				Nov. 1	0,	1946	Mary	land		
		land ow		10a. State 10b. Count	/		10c.	City, Town or L	ocation						1	0d. Inside City Limits		
		be filed within 72 hours after death with the Maryland tial Hyglene. Indicate then "natural", or items 23a or 28a-f ehow other then "natural", or items 23a or 28a-f ehow event, the Medical Examinar must be notified at	to	Maryland Harfo	bra			Joppato	N.770.0							1 □ Yes 2 □ No		
		or 288	Director	10e. Street and Number	<i>-</i>			OOPPOR	10f. Zip	Code			10g. C	itizen of V	Vhat Cour	ntry?		
		238 c	aiD	1180 Plaza Cir	cle	<u> </u>				21085	5			USA				
		r dea	Funerai	11. Marital Status		Armed F		U.S. 13.	Was Deced	dent of Hisporty Cuban,	panic Origin? (S , Mexican, Puer	Specify Yes or No to Rican, etc.)	o-		e - Americ	ean Indian, etc.		
	36	s after , or its	ьу Е	1 ☐ Never Married 2 🔀 Ma 3 ☐ Widowed 4 ☐ Divorce		If Yes, G			1 🗆 Yes		Specify:			Specify				
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7	212	filed withi Hygiene. other then	Eo	Elementary/Secondary (0-12)		College	(1-4or 5+)	Mine	۲ <u>۰</u>				Sa	and &	Grav	vel		
-	bu	be file ital Hyg od otha event,	Bec	17. Father's Name (First, Middle	Last)		_			1	18. Mother's Nar	me (First, Middle	, Maide	n Sumam	ө)			
9	<u>a</u>	Menta Menta arked	To	Ellsworth Russe	211	Brode				E	Clizabet	h (mmn)	Duc	lley				
0	a	2 sho and is mu		19a. Informant's Name/Relation								ural Route Numb			State, Zip	Code)		
<u>_</u>	2	s 1 and 2 should be f Heath and Mental item 27 is marked o other traumatic eve		David E. Brode	Jr	. / sc					l., Jopp	a, Md.						
5/16/06	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should by Department of Health and Menta important: if item 27 is marked any injury or other traumatic a <u>once</u> .	İ	20a. Method of Disposition 1 □ Burial 2 ②Cremation			State	. Place of Disp cemetery, cre	matory or o	ther place)	į.	Date	20c. I	Location -	City or 10	own, State		
	Ħ	it. Partitude ritant:			4 Donation 5 Other (Specify) Hilltop Service Corp. 5-20-06 Towson, Md.													
	Ba	Depa Impo eny i		21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A.														
144				23a. Part1. Enter the disease, of shock, or heart faifure. Lis	r compl	lications that	caused the de	ath. Do not er	317 Conter the mod	Okesb e of dving.	ury Roa	d, Abino	gdor rrest.	ı, Md	. 210	009 Approximate		
		Dharisian		Immediate Cause (Final	t only o	ne cause on	each line.	Ghad.		· D	1,00	N				Approximate fnterval Between Onset and Death		
200		Physician /Medical		disease or condition resulting in death)	-		(or as a cons		VCIIV	Cru	Imong	4 17	Jea.	16		wenty years		
M0000		Examiner		150000000000000000000000000000000000000		_	(** 40 2 00.10	-400.000 0.7.				7						
Ø	sò	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	Due to	(or as a cons	equence of):										
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2	9 X	that the death certificed by the attending properties as	/Me	IF FEMALE:	2	23c. ff ves. o	itcome of preg	inancy						001 0-1				
g	Вох	atten atten I for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?		1 Live	birth 2 ☐ Fe	ataf death 3	□Ectopic pr □ Other (sp					Mor	e of delive oth	Day Year		
3	P.O.	the d y the	Jysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unki												
119		The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by P	Part If. Other significant condit	ions co	ntnbuting to			underlying ca	ause given	in Part I.	23e. Did t	obacco	use contr	ibute to th	ne cause of death?		
ш,	rds	v requires been sign should be	ed	Covenary		trter	y DI	lease				1 🗆 '	Yes 2	2 🗆 No	3 Prob	ably 4 □Unknown		
10	900	law requas been 2 shouk	Completed	Carchial		Ster	HOSIS					24a. Was		24b. V	Vere auto	psy findings available inpletion of cause of		
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20	Vital Records,	ician: The lav certificate has rector, page 2	Be	25. Was case referred to medical examiner?	-					- 2	26. Place of Dea	ath (Check only o						
	of V	Attending Physician: r death. ector: After this certific: by the funeral director,	ို	1 ☐ Yes 2 No	1		Inpatient 2				4 Nursing n	lome 5 Resi	dence	6 □Othe	or (Specify	()		
5		After I	on:	27. Manner of Death 1 Naturaf 5 ☐ Pend	ng	28a. Date (Moi	of Injury oth, Day Year)	28b. Time o		8c. Injury a Work?		28d. Describe	how inju	ury occurre	be			
73	Division	Attendi death. ctor: A y the fu	icat	3 Suicide 6 Could		20a Blac	a of laiver. At	hama farm at	M		es 2 No	206	Character	- 4 81 1		10		
0	⊃i∨	i di di	ertif	4 Homicide determination	nined	build	ling, etc. (Spe	home, farm, st cify)	treet, ractory	, опісе		City or To	wn, Stat	ina ivumbe ta)	er or Hura	l Route Number,		
M		Hospital or 24 hours afte Funeral Dir tely filled in	a C	29a. Certifier 1 Certifyi	ng Phy	sician: To th	e best of my k	nowledge, dea	th occurred	at the time	, date and place	, and due to the	causal	s) and mar	nner as st	ated.		
1	1)		Medical Certification;	(Check only 2 Medica one)	Exami	ner: On the and mai	pasis of exami ner stated.	nation and/or in	nvestigation,	in my opir	nion, death occu	, and due to the irred at the time,	date an	nd place, a	nd due to	the cause(s)		
	/	To the To the Comple	Me	29b. Signature and title of certifi	ər	۸		·	290	. License r	number		29d. Da	ate signed	(Month,	Day, Year)		
				> Kuma	WC	xur mī				D33	42		ma	au	П.	2006		
		Ful		30. Name and address of person	who c		se of death (It	em 23a) (Type	, Print)	ιΛ	S	-(t)	.00	0.				
		211		LEUIN DY	140	or w)	SAVIC	KONY	WAN	ve 15	HIMP	MIL) 2	101	4		
		Sta Registi		31. Date filed (Month, Day, Year	3 20	06 32	Aegistrar's Sig	nature	made i	ì								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [2] [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** SARAH BURLEY 4:32 PM MAY 20 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOS PITAL RANDALISTOWN BALTIMORE NORTHWEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 A **Funeral** 1 M 2 F 8 218-28-1019 Yrs. Director November 21, 1922 Usual Residence of Decedent 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits - how in then "netural", or itema 23a or 28a-f ehov the Medical Examiner must be notified at 1 Yes 2 70 Director Baltimore Randallstown MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 393 Nemo Road USA 21133 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: AFRICAN 3 ₩Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) 14 Aide 8 Nursing LU Therem Pages 1 and 2 should be filed vitner of Health and Mental Hygie tant: If item 27 is marked other i jury or other traumatic event, IL. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel ၉ Lewis Daisey Gunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Roule Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Heath ar Importent: If Item 27 Is any injury or other trau Ellen /Daughter murray 3937 Nemo Road, Randallstown MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Fonest VA May 26,2006 Own, smills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hati P. Cluse Funeral Sewice, P. A.
5126 Belance Road Bultmone MD 21206-5105 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOMYOPATHI Physician ISCHEMIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The faw requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medicai use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy sete hes been signed by the atter page 2 should be detached for in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate hes autopsy 1 Yes 1 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 2 Accident 5 Pending investigation To the Hospitel or Attendin within 24 hours after death.

To the Funerel Director: All completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54352 2006 7-0 MAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MiRCEA TODOR NORTHWEST HOSPITAL 5401 OLD COURT ROAD RANDALISTOWN MARYLAND 21133 31. Date filed (Month, Day, Year) MAY 2 3 32. Rigistrar's Signature State 2006 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Mx Year CHARLES BAUMEL 9:07 AM 2006 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL NORTHWEST BALTIMORE RANDALISTOWN If Under 1 Year If Under 24 Hrs. 8.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth **Funeral** 01/23/1926 1 M 2 □ F 214-22-8562 80 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location wohe 10d. Inside City Limits r than "natural", or iteme 23a or 28e-f ehov the Medical Examiner must be notified at MD N/A BALTIMORE 1 ¥Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6317 PARK HEIGHTS AVENUE #316 21215 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. filed within 72 hours after IQYes 2 □ No WWII IYes, Give Year or Dates: 1 ☐ Never Married 2 1 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No þ Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER TAVERN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill thent of Health and Mental H tent: If item 27 is marked others. BAUMEL SAMUEL **ESTHER** FREEDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6317 PARK HEIGHTS AVENUE #316 - BALTIMORE, MD 21215 LORRAINE B. BAUMEL / WIFE or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of importent: If any injury or once. MOGAN ABRAHAM CEM. 4 ☐ Donation 5 ☐ Other (Specify) 05/22/2006 ROSEDALE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner OBSTRUCTION INTESTINAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical ettending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the e 9 Unknown 9 Unknown certificete has been signed by rector, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2/2 No 2 No 1 Yes 1 Tyes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this After t Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: , 3 🔲 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō To the Hospitel within 24 hours a To the Funerei C completely filled the Hospitel Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 17 D54352 MAY 2006 50 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIRCEA TODOR NORTHWEST HOSPITAL SHOT OLD COURT ROAD RAWDAUSTOWN MARYLAND 21133 31. Date filed (Month, Day, Year) MAY 2 3 2006 32. Registrar's Signature State Registrar

06-03312 Macy Clark

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

y Olark		1- For State Crivial yiand / Department of Health and Wentar Hy Registrar		eg. No.	6 1614
Physicia	an/	1. Decedent's Name (First, Middle,Last)	Date of Deat Month		3. Time of Death
dical Exami	ner	Macy Gail Clark 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	May 16, 2		1258 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital Baltimore			1
Funeral		5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Bin	th(MM/DD/YYYY) 9. Bi	thplace (State or
Director		220-37-0741 1 M 2XF 13 Yrs. Months Days Hours Min.	Dec. 1	4. 1992 Forei	^{gn} ^{Duntry} Maryland
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* any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
land f sho	ō	Maryland N/A Baltimore			1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 10f. Zip Code	11	Dg. Citizen of What Cou	Ė
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Lx miner must be notified at once		3905 Woodlea Avenue 21206 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No	U. S. A.	ican Indian, Black,
eath w items ust be	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, etc.	reart indiant, black,
fler d		3 Widowed 4 Divorced If yes, Give Year 1 Yes 2 X No specify:		Specify: W	hite
136 hin 72 hours after e. than "natural", edical Ex. miner	d be	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired.)		16b. Kind of Business/	Industry
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Within the the the	Completed	6 Years Student 17. Father's Name (First, Middle, Last) 18.Mother's Name	(First, Middle, M	Special &	ducation
21215-0036 hould be filed within 7 and Mental Hygiene. is marked other than tire event, the Medica	Be C			Johnson	
21; ould b d Men s mar	은	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R	tural Route Num	nber, City or Town, State	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. Iant: If item 27 is marked other than or other traumatic event, the Medical		Dale Clark (Mother) 3905 Woodlea Avenue, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	Baltim	ore. Marylo	ind 21206
of He		1 Burial 2 X Cremation 3 Removal from State crematory or other place)			!
Baltimore, permit Pages I ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify: Bayview Crematory 05/2	2/2006	Baltimore	, Maryland
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sch	imunek	Funeral Hon	ne Inc.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	r respiratory arre	est, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Asphyxia			Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):			
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Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed by notes after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED AMENDED			
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P.O. Bo. that the derined by the adetached for	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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ords, w requir is been s should!	olete		24a. Was autop	sy prior to	topsy findings available completion of cause of
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Division tal or Attendir us after death.	icat	2 Accident Investigation May 13, 2006 1923 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S	Street and Number or Ru	ural Route Number, City
Division Hospital or Attend 24 hours after death Funeral Director:	Certification:	- Calcius	or Town, S 3905 Wood	^{itate)} lea Avenue, Baltin	nore, MD
Hosp 24 hos Fune etely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the caus	e(s) and manner as sta	ted.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	t the time, date	and place, and due to the	ie cause(s)
- > - >	Ź	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
		tate homa-folds		May 19, 2006	
OX		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 2120	1	
<i>X</i> U	tate	Of D. Shakara at D. V.)	-, <i>D</i> 2120		
3	relia	MAY 2 3 2006 Heaven & South			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🖺 🖺 🔓 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** May 20, 2006 Year 0710 Mary Marie Campbell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Harford Upper Chesapeake Medical Center 8. Date of Birth (Month, Day, Year) Jan. 19, 1942 5. Social Security Number If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign WVa 1□ M 2□ F Days Hours Yrs. 213-40-0268 Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Edgewood Md. Harford 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21040 1514 Edgewood Road U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2 No Specify: 3 Widowed 4 ADivorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 6 years College (1-4or 5+) food service 18. Mother's Name (First, Middle, Maiden Sumame)
Margaret Lucille Pritt 17. Father's Name (First, Middle, Last) unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 87, Whiteford, Md. 21160 Debbie Robinson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 5/23/2006 Bel Air, Md. 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gdns. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. Duan 610 W. MacPhail Road, Bel Air, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic a denocationo disease or condition resulting in death) Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown

Physician /Medical **Examiner**

Department of Health a importent: if item 27 is any injury or other tree once.

Funeral

Director

28a-f show

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other treumatic event, the Madical Examiner must be notified a

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Baltimore, Maryland 21215-0036

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Dampbell, Mary

attending physicien and for use as the burial-transit Completed by Be Certification; To the

this certificete

Director:

within 24 hours a

filled in by

Medical

Hospital or Attending Physician:

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

25. Was case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

(Check only one)

24a. Was an autopsy 1□ Yes

performed? Yes 2 26. Place of Death Check only one

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Other 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irina Mikityanskaya, M.D., 520 Upper Chesapeake Drive, Bel Air, Md. 21014

1 X Inpatient

28a. Date of Injury (Month, Day Year)

31. Date filed (Month, Day, Year) 2006 State Registrar

32. Registrar's Signature

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

3 DOA

Funeral Director

		1 - For State Registrar	State o	f Maryland		artment of I		Mental Hygie	- 2 U U	16 15148				
Physic /Medi		1. Decedent's Name (First, Middle, Patricia As		ell				2. Date of Death Month		3. Time of Death ear 6: 32 PM				
Exami		4a. Facility Name (If not institution, SiNAi HOSPITAL	OF BAL	TIMORE		BALTIN	OF Location of Death		4c. County of E	Death n/a				
uneral irector		5. Social Security Number 149–64–9842 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. Ia	Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye July 23,	ear)	Birthplace (State or Foreign Country) New Jersey				
28a-f show	Director	10a. State 10b. County Maryland n/a 10e. Street and Number		,	Town or Lo			100	Citizen of Wha	10d. Inside City Limits 1 ∑Yes 2 □ No				
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if Item 27 le		Lynda R. Astle / Mother 4014 Roland Avenue, Baltimore, Maryland Commence of Disposition 1 Burial 2 Cremation 3 Removal from State 4014 Roland Avenue, Baltimore, Maryland Commence of Disposition (Name of Commenterly, crematory or other place)												
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eral Directorilled in by the	O	3 Suicide 6 Could no determin	ed 28e. Place buildin	of Injury - At homing, etc. (Specify)				City or Town, Sta	ate)	Rural Route Number,				
To the Fun completely f	Medicai	29b. Signature and title of certifier	and mann	er stated.	edge, death n and/or inve	occurred at the timestigation, in my of	pinion, death occurre	and due to the cause and at the time, date a 29d. E	(s) and manner and place, and do	lue to the cause(s)				
6		30. Name and address of person wh		of death (Item 2		RES-000 May 20, 2006								
Sta Registr		Ruchi Pu 31. Date filed (Month, Day, Year) MAY 2 3 2	32. Re	gistrar's Signatur		lai Hospit	al of E	ALTIMORE	3					

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and	≥ 21		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside C	ity Limits
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uid be	rked tic av	ToB	Frank Cole					Hel	len V.	Miles				
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COLOS, w requires t	en sig Juld b									1 □ Ye	s 2 No	3 Pro	bably 4 🔀	Unknown
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a The	certificate has t irector, page 2 s		OF Was and found to medical					00 Bi		1 ☐ Yes 2	X No	1 🗆 Yes	2 No	
Or Vital Physician: 1	s certii directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatio	ent 2 🗆	ER/Outpatie	nt 3□ DOA	Othor	e of Death <i>(Chi</i> ursing Home			Other (Spec	ify) HOSP	ICE
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DIVISIO To the Hospital or Attendi	within 4* hours are beaut. To the Funeral Director: Aber this certificate he completely filled in by the funeral director, page	caic		rsician: To the best inar: On the basis o										(c)
tha H	the F	Medical	one)	and manner st				ense number					, Day, Year)	
2	200		29b. Signature and title of certifier)437	25		70. Date 319	-/27	106	
	DXI		30. Name and address of person who c	ompleted cause of	death (Iter	m 23a) (Type		()/	-3			/	100	
and diver			DR. TARIQ MAHMOO	D 2300 D	ULAN	EY VAL	LEY RD.	TIMON	IUM, M	D 2109	3			
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- 1613	Regist	ıar	MAY 2 3 2006	All Muse	- Sign	402	Carl .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No.-2. Date of Death Decedent's Name (First Middle Last) 3. Time of Death Month **Physician** 2006 /Medical 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner USOr MMORE If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day, Year) cial Security Number Birthplace (State or Foreign Country) **Funeral** 10M 20 F Months Days Hours Min. Yrs. Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Completed by Funeral Director 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 238 Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. 2 Married 1 Never Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: NAV Y Specify: (1) / T 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Is marked other than "nature aumatic avant, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Home Elementary/Secondary (0-12) College (1-4or 5+) Owner Improvement 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Be Jeorge 19a. Informant's Name/Relationship (Type, Pring) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) henowith 30 20c. Location - City / Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of I Importent: If its any injury or o one. ō 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State -24-06 Evans Funeral 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Fundan Service License 22. Name and Address of Facility Funeral chapel 8800Hartord MB 21234 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ENDSTAGE DEMENTIA Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.0. the a 9 Unknown 9 Dunknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s certificate 217 No 1 ☐ Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 25 No Other: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 □ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation in my opinion death account at the cause(s) and manner as stated. 29a. Certifier Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 25642 05 . Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. CHARLES STREET aulkner OWSON MD Z1204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 3 2006 Registrar 13 4 P

ax

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#27,pen/ff.g859,9/18/05 II item#25, pen/ff.

Amend Items 27, 29d per Dr., G855,05/23/06dhp

Reg. No.

Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 7:10 PM D. Clark Alan 106 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Hospital Center Prince George's Cheverly | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O9-17-1956 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Virginia 49 Yrs. 579-76-4238 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumstic event, the Mydical Examinar must be righted at 1 X Yes 2 No D.C. Washington Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5000 H Street, S.E. 20019 U.S.A. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. o filed within 72 hours after d. Il Hygiene. other then "neturel", or Item 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Day Program Worker Day Program 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other treumatic event Be Harry Clark Roberta Reynolds 19b. Mailing Address (*Street and Number or Rural Route Number, City* or Town, State, Zip Code) 7243 Sheila Turn Clinton, Maryland, 20735 19a. Informant's Name/Relationship (Type, Print) Linda Langley/ sister 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 04-06-2006 ' 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 21. Signature of Funeral Service Licenson 3447 14th Street, N.W. Washington, D.C. 20010 0025 23a. Part Enter the disease, of complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Priysician /Medical Due to (or as a consequence of) Examiner UFMATOMA Sug ouzate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Figury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 2 X No 1 Yes 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 XYes 2X No this TESIDENT

On (Street and " 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification; After 5 Pending 1 ☐ Yes 2 XNo after death. 2 Xaccident investigation narch 27,2006 UNKNOWN 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 T Homicide 5000 HST-SE WAShington & 20019 within 24 hours a To the Funerel C KESIGENI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29c. License number PMO School 29d. Date signed (Month, Day, Year) April 3, 2006 29b. Signature and title of certifie 10055703 who completed cause of death (Item, 23a) (Type, Print) 30. Name and address of person 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 3 2006 many Registrar

		1 - For Amend Items Registrar 1. Decedent's Name (First, Middle, Last		c:,G855,05	123/06dhl tificate of	Death	2. Date of Dea			1010
Physici /Medic		JERRY	,		COX		Month MAY	Day	2006	3. Time of Death
Examin	er	4a. Facility Name (If not institution, give JOHNS HOPKINS B		CENTER MEDICAL A		r Location of Death		4c. Coun	ty of Death	
Funeral Director		216-42-5636	x 7. Age M 2□F	(In yrs. last birthday) 62 Yrs.	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb 23,	, Year)	9. Birthp Cour	olace <i>(State or Forei</i> ntry) unk
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Sa-f s	Director	MD		Baltimore						1 - Yes 2 □ I
a or 2		10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Cour	itry?
78 23 THE	Funerai	4320 Clareway #67	12. Was Decedent E	ver in U.S. 13. \	21213 Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	USA 14. Ra	ace - Americ	an Indian,
giene. r than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	D .	fYes, specify Cuba 1 ☐ Yes 21X No	Specify:	o Rican, etc.)	Spec	•	ite
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and Ment is marked eumatic	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailin	g Address (Street	and Number or Ru	ıral Route Numbei	r, City or Town	n, State, Zip	Code)
of Health a item 27 to other tree		Bayview Med Cent	er		Eastern			MD 212	24	
Department of Health and Men Important: If Item 27 is marke any injury or other treumatic once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☒ Other (Specify)	in state/	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	eθ)	Date	20c. Location	- City or To	wn, State
Departi importi any ini		21. Signature III. oral Service Lice s	Wade Dire	extor S	Name and Addre Late Anat altimore	ss of Facility Comy Boar MD 2120	d 655 W.	Balti	more S	Street
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		30. Name and address of prison who co		ath (Item 23a) (Type, I +940 EA	STERN A	TVENUE	BALT	IMORE	,ME	21224
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	the N 28a-f	Director	10e. Street and Number	iio a cii	IIa	ZIEL	10f. Zip Code			10g. Citizen of Wh	at Country?	
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	/Medical Examiner	Q.	resulting in death)	Due to (or	as a consequen	ice of):						
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Vital	Attending Physicien: Thraden. Thraden. setor: After this certificate by the funeral director, pag	Be	25. Was case referred to medica examiner?	Hospital:			2 DOA Oth	041	ath (Check only)	/	Hasisted	
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	To the within 2 To the complet	Me	29b. Signature and title of certile	1111			29c. Licens			29d. Date signed (_
	->-0		> Kinty	SHIPDIN	>		DS	0339	3	May 2	20, 2006	
	10		30. Name and address of person	who completed cause	of death (Item 23	3a) (Type, I	Print)	- 0.	<i>~ (</i>	1	20, 2006 7 21044	
			31. Date filed (Month, Day, Year)	MU 110	strar's Signature	ille Y	aluxeu	IKMY	Colun	ibia, MI	21044	
	Sta Regist	ate rar	MAY	3 2006	Carrier d	A.S.	GORNES -	,				

State of Maryland / Department of Health and Mental Hygiene UUD Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** May 18, 2006 Allen Clas 1:20pm M Edward /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6828 White Rock Road Sykesville Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1₩ 2□F 94 Yrs. ΜĎ 220-07-7746 28, Director Usual Residence of Decedent 10a. State 10b. Counts 10c. City. Town or Location 10d Inside City Limits r than "neturel", or iteme 23s or 28s-f show the Medical Examinar must be notified at MD Carrol1 Sykesville 1 ☐ Yes 2 X No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6828 White Rock Road 21784 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Machine/Agriculture Machinest / Farmer other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lipiry or other traumatic event gotes. Be Emil Robert Clas Bessie Glenelda Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marguerite A. Clas (Spouse) 6828 White Rock Rd., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial X Cremation 3 Removal from State All COunty Cremation 5/24/06 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee HATCHI TUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 Huge 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Set and Death Immediate Cause (Final Dementia **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to minisciples cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner physicien and s the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Constibution 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Osteoarthritis Severe 31 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after within 24 hours a Medicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 33681 5/18/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Progress Way, Suite 114 1380 MCEVOY, MD 3 2006 State

DHMH 17 Rev 1/2001

Registrar

_			1 - For State Registrar	State of Maryla		artment of I			giene Reg. No.	06	16155
	Physic	ian	Decedent's Name (First, Middle, Last)	_				2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi	cal	Leon Raymond	Casner		# C' T-		May		2006	12:50 PM
	Examir	ner	4a. Facility Name (If not institution, give s			_	or Location of Death			ty of Death	
	Funeral	1874 E	Upper Chesapeake I 5. Social Security Number 6. Sex	7. Age (In yrs	⊇ r s. last birthday)	Bel A	If Under 24 Hrs.	8. Date of Bin	th	rford 9. Birthp	lace (State or Foreign try)
	Director		212-80-1470	KM 2□F 4.5	Yrs.	Months Days	Hours Min.	Jan. 5			zland
_	and		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ecation					Od. Inside City Limits
	Maryl febo	ō	Margaland Harefored		-						1 ☐ Yes 2 No
	with the Maryland a or 28a-f ehow	Irec	Maryland Harford 10e. Street and Number		Fallst	10f. Zip Code			10g. Citizen of	What Coun	try?
	23a c	aiD	17 Mountain Road			21047			USA		
5	after dea	uner		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of I	Hispanic Origin? (Sp pan, Mexican, Puerto	ecrity Yes or No Rican, etc.)		ce - America	
J 8	rs afte	oy Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	İ	1 ☐ Yes 2 📉 No			Speci		
50P1	within 72 hours after death with the Maryland one. one. https://www.artural.com/ems 23a or 28a-f ehow he Marical Examinar must be notified at	Completed by Funeral Director	15. Decedent's Educ	cation		dent's Usual Occu			16b. Kind of 8		ite ustry
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4 2	TI 70 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		12		Anima:	l Contro	l Officer				rnment
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'O \(\frac{5}{2}\)	2 should and Men is marks sumatic	2	19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address (Street	Margaret			State. Zip	Code)
0	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		Patricia Casper -	Wife	Taller Co.	ountain I		Lston, M			
00 or	of He of He if item		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Re	20b.	Place of Dispo	sition (Name of natory or other pla		Date	20c. Location		
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$\mathcal{U}_{\overline{\mathbf{g}}}$	permit. Pages Depertment of I important: if its eny injury or o		21. Signal, rid of Full V 1-3 mice License	is Kernet	50		coadway St		Bel Air,		, P.A. land 21014
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the dea e cause on each line.	ath. Do not ent	er the mode of dyl	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	intra co	rebi	al	Hemar	-ha	52		Onset and Death 24 hours
	Examiner			Due to (or as a conse	quence of):				3		•
5	- i V-	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence or):						
3	certificate be executed adding physicien and was the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
156	be ex icien a burial	ical Ex	resulting in deathy Last	Due to (or as a conse	quence at);						
45	ficate physis the		d								
S Q	eath certific	/W	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pregr					23d. Da	ite of deliver	v
800		Physician/Med	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnanc Other (specify) _	У				Day Year
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	signed d be def	d by	Part II. Other significant conditions con		-		ven in Part I.		obacco use con ′es 2 □ No		cause of death?
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9 8	The lay te has age 2	Completed	77000	Jeen				autop perfor	sy med2	prior to com death?	sy findings available pletion of cause of
		Bec	25. Was case referred to medical examiner?	* V41/W4			26. Place of Deatl	1 ☐ Yes		1 ☐ Yes 2	!L No
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3 5	ding Ph h. After th funeral	lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe h	ow injury occur	red	
Sign	Attending Physician: r death. ector: After this certific by the funeral director,	ficat	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	nome farm stre		Yes 2 □No	28f. Location (S	treet and Numb	or or Pural	Pauta Alum has
No.	afor safter	Certification:	4 Homicide determined	building, etc. (Speci	ify)	set, factory, office		City or Tow	n, State)	er or Aurar	Aodie Number,
3	To the Hospital or Attentwithin 24 hours after death To the Euneral Director: completely filled in by the	edical C	(Check only 2) Medical Examin	ician: To the best of my kn er: On the basis of examin	owledge, death ation and/or inv	occurred at the tir	me, date and place,	and due to the o	ause(s) and ma	anner as sta	ted.
	within 24	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signe		
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	4		30. Name and sopress of person who con	mpleted cause of death (Ite	m 23a) (Type, I	Print) UPP	5 Chega	peak	170-C.	, 20	Coder
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	Physici /Medic Examin	al	Decedent's Name (First, Middle, L A-Chun C 4a. Facility Name (If not institution, gu	hiou	·)		4b. City, To	wn, or l	Location o	f Death	2. Date of Month May	20,	Day 2006 4c. County o	Year of Death	3. Time of Death 9:30 P
I	Funeral Director		212-43-7212		ge (In yrs. las	st birthday) Yrs.	If Under 1		dale If Under 2 Hours	24 Hrs. Min.	8. Date of (Month, July	Day, Yea		9. Birthp	lace (State or Foreign
	e Maryland la-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Baltim	ore	10c. City,	Town or Lo	cation edale		_				<u> </u>		0d. Inside City Limits 1 ☐ Yes 2 🛣 No
-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel; or Items 23a or 28a-f show ant, Ite Macical Exacilier must be notified at	ed by Funeral Director	10e. Street and Number 10 Baltistan Cou 11. Marital Status 1 □ Never Married 2 □ Married 3 ☆ Widowed 4 □ Divorced 15. Decedent's 6	12. Was Deceden Armed Forces 1 Yes 2 X If Yes, Give Year or Dates	i? [No :	16a. Dece	10f. Zip Co 21 23 Was Deceden f Yes, specify 1 Yes 2 dent's Usual C	No	Specify:			Ur No-		Stat America, White,	es Indian, etc.
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Records, P.	The law requires that the de ste has been signed by the a bage 2 should be detached to	Completed by Ph	Part II. Other significant conditions	contributing to death	but not result	ing in the u	nderlying cau	se give	n in Part I.		1 24a. W	□Yes	2 No :	Prob	psy findings available npletion of cause of
Division of Vital F	ding Physician: h. After this certifica funeral director.	Certification: To Be Co	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manger of Death 1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not	be -	jury 2 Da <i>y Year)</i>	R/Outpatier 8b. Time of Injury	28c	Other	r: 4 □ Nui	rsing Hor	1 ☐ Ye (Check on me 5 X R 28d. D~scri	s 2 (x) esidence be how in	6 Other	Yes r (Specify	<i>(</i>)
Divi	or Dir	edical Certifi	4 Homicide determine 29a. Certifier 12 Certifying F (Check only 2 Medical Ex.	building, o	etc. (Specify) st of my knowl of examination	ledge, deatl	n occurred at	the time	e, date and	d place, a	City or and due to t	Town, Sta	ate) (s) and man	ner as st	Ated.
	To the Hospitel within 24 hours To the Funerel completely filled	Med	29b. Signature and title of certifier	and manner s	stated.	MD			number 28	94	9	29d. E	Date signed	(Month, 1	
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			1 - For State Registrar	State of	Marylan	•	artment rtificate			and M	•	giene Reg. No	200	6	16157
	Physici		1. Decedent's Name (First, Middle Yeshi D. Cour					-			2. Date of De Month May 2	Da	y Ye	ar	3. Time of Death 3:00A
	/Medio Examin		4a. Facility Name (If not institution		ber)		4b. City, T	own, or	Location o	of Death	1147 2	_	. County of C	eath	J. OUR
			Montgomery Ho				Rocky			DA I I ea			lontgor		
Н	Funeral Director		5. Social Security Number 032-66-9065	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. i	Ven	If Under 1 Months	Days	If Under:	Min.	8. Date of Bir (Month, Da Feb. 1	ıy, Year)	9. 949 Et	Count	ace (State or Foreign try) opia
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	r 28a	Director	10e. Street and Number	omer y	I KO	CKVIII	10f. Zip (Code				10g. Cit	lizen of What	Count	try?
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	er der Iteme	Funeral	11. Marital Status	12. Was Deced	ces?	S. 13.	Was Decede f Yes, speci	ent of His fy Cubar	spanic Orig n, Mexican	gin? (Spe i, Puerto F	cify Yes or No Rican, etc.))-	14. Race - A Black, V		
936	within 72 hours after deeth with the Maryland ene. than "naturel", or Iteme 23e or 28e-f ehow he Madical Examenation Codified at	by	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 If Yes, Give Year or Da)		1 ☐ Yes 2	⊠ No	Specify:				Specify:	Bla	ck
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2	ne.	mple	Efementary/Secondary (0·12)	College (1-	4or 5+)	life.	DO NOT use	e retired)			•				
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an	ild be iental ked o	To Be	Debebe Hailema						_	na A			,		
ary	and N		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address ((Street a			Route Numb	er, City o	or Town, Stat	e, Zip	Code)
∑.	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or iteme 23e or 28e-f show entry or other treumatic event, the Madical Examinat must be notified at ONGs.		Aynalem B. Me	sfin/Daugh					1d Co						20852
Baltimore, Maryland	ages 1 of H or of		20a. Method of Disposition 1 Burial 2 Cremation		1 0	tace of Dispo emetery, crer Lv Tril	natory or oth	e or her place) M	lay 2 200	5,		ocation - City		
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Ba	Depe Impo eny ir	l, l	38-10	- Com	. MO	0803 R	ockvil	lle,	Inc.	30	0 West 2085	Mon 0-28	tgomer	y A	venue
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea	used the death								<i>U.</i>		Approximate Interval Between
	Physician		fmmediate Cause (Final disease or condition	_a Lu	ng Can	cer									Onset and Death
	/Medical Examiner		resulting in death)	Due to (c	or as a consequ	uence of):									
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (c	r as a consequ	Jence of):								-	
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	c											
8760,	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (c	r as a consequ	uence of):									
687	physi s the t	edicai		d											
Вох	h certi	M/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregna th 2 ☐ Fetal		Ectopic pre						23d. Date of	defiver	у
P.O. B	Attending Physicien: The law requires that the death certificate be executed refash. r death. ector: After this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		nt at time of de		Other (spe						Month	(Day Year
	that the		Part II. Other significant condition	ons contributing to dea	ath but not resu	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did t	obacco u	use contribut	e to the	e cause of death?
Division of Vital Records,	w requires been signe should be	ed by									10	Yes 2	□ No 3 □) Proba	ibly 4 ∰Unknown
ဝင္ပ	law requias been	Completed									24a. Was		24b. Were	autop to com	sy findings available
<u>س</u>	ystcien: The lis certificete hadirector, page	Con										rmed? 2 XNo	death	1?	2 🗆 No
₹	slcien: Th certificete irector, pag	o Be	25. Was case referred to medica examiner? _1 ☐ Yes2 ☒ No	Hospital:	patient 2	5D/0		! Othe	-		(Check only o		. 16	-	TT .
٥	g Physical this	n; To	27. Manner of Death	28a. Date of		28b. Time of Injury		c. Injury Work			e 5 Resi 8d. Describe			(pecify	Hospice
<u>S</u>	ending eath. or: After he funer	atlo	1 XNatural 5 Pendir 2 Accident investi	gation	, Day rear	injury	М		es 2 1	No					
Š	p # 를 급	ertification;	3 Suicide 6 Could 4 Homicide determ	ined 289. Place	of Injury - At ho g, etc. <i>(Specif</i> y	me, farm, str	eet, factory,	office		2	8f. Location (City or To	Street an wn, State	nd Number or	Rural	Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	O	29a. Certifier 1 🔀 Cartifyir	ng Physician: To the b	pest of my know	wledge, death	occurred a	t the time	e. date and	d place, a	nd due to the	cause(s)	and manner	as sta	ited
	n 24 h	Medical	(Check only 2 Madical one)	Examinar: On the bas and manne	sis of examinat	tion and/or in	vestigation, i	in my op	inion, deat	h occurre	d at the time,	date and	d place, and	due to	the cause(s)
	To the company	Σ	29b. Signature and title of certifie	r			29c.	License	number			29d. Dai	te signed (Mi	onth, D	ay, Year)
	of		1	<u> </u>	MI			3563	35			May	22, 2	006	
	0		30. Name and addless of person					ال م	Do = 1.		M - · ·	.1 -	1 000		
	Sta	te	Joseph Kaplan,	32. 40	gistrar's Signa	ture		aQ,	KOCK	VIIIE	, Mary	Lanc	1 208	2.5	
	Registr	ar	MAY 2 2	2006	asser 1	1/ 60	andi)								

			1 - For State Registrar		aryland / Depa		ealth and l	Mental Hyg	_	15158
	Physici		Decedent's Name (First, Middle					2. Date of Dea Month	nth Day Year	3. Time of Death 12:47 PM
	/Medi Examir		Harry Dale Di 4a. Facility Name (If not institution	etricn a, give street and number)		4b. City, Town, or	Location of Death	<u> May 21</u>	L, 2006 4c. County of Death	
1			4702 Powder Mi			Beltsvil	le		Prince Ge	eorges
	Funeral Director		5. Social Security Number 216-60-1116 Usual Residence of Decedent	6. Sex 7. Age 1	(In yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day May 3,	1954 9. Birth Mary	place (State or Foreign otry) Land
	yland now		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	e Mar	Funeral Director	MD Princ	e Georges	Beltsvil	le				1 ☐ Yes 🌋 No
	vith th	Dire	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What Cou	ntry?
	s 23s	erai	4702 Powder Mi	II Road 12. Was Decedent B	Ever in II S 13 1	20705	mania Origin? (S	poety Ves es No	USA 14. Race - Ameri	ogo Indiae
336	s within 72 hours after death with the Maryland liene. r then "naturel", or items 23a or 28a-1 show the Medical Examiner must be conflied at	۾	1 ☐ Never Married 2 🛂 Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	lo l	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 🛂 No	Specify:	white	Specify:	
21215-0036	within 72 hou ene. then "nature he Medical E	Completed	15. Deceden (Specify only highe: Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or 5	(Give	dent's Usual Occupa kind of work done di DO NOT use retired)	tion		16b. Kind of Business/In	
	filed witi Hygiene other the	Com	12	College (1-401 5		to Mechani	ic		Contemporar	y Classics
Maryland	ed la b	Be	17. Father's Name (First, Middle,						Maiden Sumame)	
7	should nd Mer marke imaric	ို	Harry H. Diet. 19a. Informant's Name/Relations		10h Maile	Addess (Cassa)			McLellan	
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Nancy M. Stefa		4702	Powder Mi		Beltsvi	r, City or Town, State, Zij 11e, MD 207	05
Baltimore,	permit. Pages Department of I Importent: If its any injury or of		1 Burial ZXCremation			natory or other place			20c. Location - City or To	
Ħ	permit. P. Departme importent any injury once.	1	4 ☐ Donation 5 ☐ Other (S	A	Metro Cre			-	Baltimore,	maryland
B	Depa Impo any i		KIM X	Ach Oas	194	Cremation 299 Freder	Society	of Mary d Raltim	land, Inc. ore, MD 212	28
760,	Physician / Medical Examiner and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien are provided by the physicien are provided by the physicien and physicien are provided by the physicien and physicien are provided by the physicien and physicien are provided by the physicien and physicien are provided by the physicien and physicien are provided by the physicien and physicien are physicien and physicien are physicien and physicien and physicien are physicien and physicien and physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien a	icai Examiner	23a. Pan1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Date to (or as a	Cancer - M consequence of):		, such as cardiac	or respiratory arm	951.	Approximate Interval Between Onset and Death
P.O. Box 68	death certific e attending p id for use as i	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 6 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
	uires that signed b		Part II. Other significant condition	ns contributing to death bu	t not resulting in the ur	derlying cause giver	n in Part I.		pacco use contribute to the	1
Vital Records,	: The law requires that the cate has been signed by th page 2 should be detache	Completed						24a. Was a autops perform	y prior to con	psy findings available mpletion of cause of
ta	ician: Th certificate rector, pag	a	25. Was case referred to medical				26 Place of Deal	1 ☐ Yes 2 th (Check only only	2 Le No 1 □ Yes	202No -
<u> </u>	Physician: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatien	Othor			ince 6 ☐Other (Specifi	v)
Division of	ding h. After fune		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investig	28a. Date of Injury (Month, Day ation	Year) 28b. Time of Injury	28c. Injury a Work? M 1 □ Ye	at		w injury occurred	
Divis	tal or Attend rs efter death al Director: , ed in by the f	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		ry - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Sti City or Town	reet and Number or Rura , State)	l Route Number.
	To the Hospital or Attenwithin 24 hours efter deation to the Funeral Director: completely filled in by the	edicai	one)	g Physician: To the best of examiner: On the basis of and manner stat	examination and/or inv	occurred at the time estigation, in my opin	a, date and place, nion, death occur	and due to the ca red at the time, da	tuse(s) and manner as state and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1.0004	1,	29c. License	number	29	9d. Date signed (Month,	Day, Year)
	20		Milledent	. weeks	<u></u>	DD2374	3		lay 22, 2006)
	20		30. Name and address of person	· ·		•	O			
	Sta	te_	Martin D. We 31. Date filed (Month, Day, Year)	32. Riggistra	Greenway (ricie Dri	ve Green	nbert, M	20//0	
	Registr		MAY 2	3 2006 Amari	2. 11. Cal	and I				

		1	State of Maryland / Dep	artment of Health and Natificate of Death	Mental Hygiene	006 6 59
			Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
	Physicia /Medic		Dale Conway Davis		May 19, 2006	7:15 P ^M
	Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. Co	ounty of Death
			Caton Manor 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday	Baltimore If Under 1 Year If Under 24 Hrs.	8. Date of Birth	N/A
	Funeral		5. Social Security Number 6. Sex 1 \times 1 \times 2 \times 7. Age (In yrs. last birthday 218-28-8201	Months Days Hours Min.	(Month, Day, Year) APR 15, 193	9. Birthplace (State or Foreign Country) Virginia
	Director		Usual Residence of Decedent		11111 15, 155	
	how		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits 1 Yes 2 □ No
	Sa-f s	Director	Maryland N/A	Baltimore	140 00	
	vith th		10e. Street and Number 3330 Wilkens Avenue	10f. Zip Code 21229	iog. Citize	n of What Country? USA
	sath v	Funeral		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- 14.	Race - American Indian,
· ^	r item	F	1 Never Married 2 Married 1 Yes 2 ANO	37		Black, White, etc.
Ö	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Madical Examinar i wat be notiliad at	þ	3 ☐ Widowed 4 X Divorced If Yes, Give Year or Dates:	1 Yes 2 ANO Specify:	51	white
21215-0036	72 h 'natu	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	rking 16b. Kind	of Business/Industry
12	within than	du	Figure 14-40r 5+)	ruck Driver	Ind	lependent
р 5	Hygid Hygid Sther ent,	Ö	17. Father's Name (First, Middle, Last)		me (First, Middle, Maiden Su	ımamə)
Maryland	fental fental rked tlc ev	To Be	Dale Conway Davis	Bar	bara Jean Sta	iggs
ary	and N			ling Address (Street and Number or Ru		
Σ.	and 2 ealth m 27	l l	lock Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of D	34 W. 37th Street	Baltimore, M	ID 21211 tion - City or Town, State
Ore	or otl	1-1	1 Burial 2 PCremation 3 Removal from State	ematory or other place)		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 le marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Madical Examinar rust be notified at any injury or other traumatic event, the Madical Examinar rust be notified at ance.			rematory, Inc. 5/ 22. Name and Address of Facility Cr		Baltimore, MD
Ba	Departimos any it		Elward A. Gregorchik	299 Frederick Ro		•
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Acute Cara	Grovercular A	en dent	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	Examine	_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b Due to (or as a consequence of):			
T	nsit	nine	Cause (Disease or injury			
	be executed ilcien and burial-transit	Exa	that initiated events c Due to (or as a consequence of):			
8760,	cate be executed oblysicien and the burial-transit	Physician/Medical Examiner	d			
	entifica ing ph e as ti	Med	IF FEMALE:		II ee	1.00
Box 6	death certificate e attending phys	lan/	23b. Was decedent pregnant in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)	23	d. Date of delivery Month Day Year
P.O.	at the de by the	ysic	1 Yes 2 No 9 Unknown			
	that hed by deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use	contribute to the cause of death?
rds	v requires t been signe should be		PAZKINSONICY		1 ☐ Yes 2 ☐	No 3 ☐ Probably 4 Dunknown
of Vital Records,	2 5	Completed	Old Care aro Voscular Ac	endent	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ě		S			performed?	death? 1 ☐ Yes 2 ☑ No
/ita	sician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Other	ath Check only one	
o	Phys this al dil	2	1 Yes 2 No 1 Inpatient 2 EN Outpati	ent 3 DOA 4 me Nursing F	Home 5 Residence 6 28d. Describe how injury	
O	ding th. After funer	tion	27. Manner of Death 28a. Date of Injury (Month, Day Year) 2 □ Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)			
Division	or Attending siter death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
ā	tal or A	Cert	Thomas Building, Sto. (openity)			
	Hospi 14 hou Funer tely fill	edicai	29a. Certifier (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf) (Check orlf)	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the cause(s) a urred at the time, date and p	nd manner as stated. lace, and due to the cause(s)
	To the Hospital or Attending within 24 hours effect death. To the Funeral Director: After completely filled in by the funer	Med	29b. Signature and title of certifier	29c. License number	29d. Date	signed (Month, Day, Year)
	F ≯ F ŏ		Whende MI Attending Dock	or \$ 21684	4 05	122/2006
			30. Name and address of person who completed cause of death (Item 23a) (Typ		D.2 (A 4.	h 11500
	5		C-V, CYRIAC BO21 KITCH	IR AUT, WASA	DRNA, M	り メハイイ
	St Regist	ate	31. Date filed (Month, Day, Year) MAY 2, 3 2006 32 Registrar's Signature			
			MAIN			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2:30 AM IBBERN MARGARET MAY 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. HUSPICE MARIS BALTIMORE DIECLA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Months Days 85 1 M 2 F 218-03-1020 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 ☐ No mo BALTIMORE MARKUILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA LOURT IEAKL 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 3 ₩idowed 4 Divorced WHITE 16a. Decedent's Usual Occupation
(Give kind of work done during most of working)
Iffe. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT 18. Mother's Name (First, Middle, Maideg Sumame) 17. Father's Name (First, Middle, Last) ITNNIE 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CT. 13 MUELLER MARKVILLE DAUGHTER TEAKWEUD MO 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State MAY 22 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) AK LAWN 200 21. Signature of Funeral Service Licensee ERCO HARFORD 22. Name and Address of Facility CHAPEL ARKUITE EVANS mo 21234 FUNERAL 23a. Parl1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 📆 Other (Specify) HOSPICE 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 2 Accident investigation

the burial-transit physicien and Box 68760 o. ۵. Division of Vital Records, certificate or Attending the Director: To the Hospital or Atte within 24 hours after de To the Funerel Directo completely filled in by the

Physician/Medical þ Be Completed

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Certification:

Medical

State

Registrar

Examiner

Physician

/Medical

Directo

Completed by Funeral

Be

2

Examiner

Funeral

Director

ir than "natural", or Items 23a or 28a-f ehow the Medical Examinar must be notified at

or other traumatic event,

permit. Pages 1 and 2:
Department of Health ar
Importent: If Item 27 Is
eny injury or other trau

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

43

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

3 Suicide

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year) MAY 2 3 2006

6 Could not be determined



2300 DULANEY VALLEY RD.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** William Deale Walter Munnikhuysen May 21, 2006 2:30am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. February 28, 1929 Months **X** M 2□ F Maryland 132-22-1161 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28s-1 show with Injury or other traumatic event, the Medical Examinar must be nutified at once. 1 ☐ Yes 🎗 🛱 No Directo Maryland Baltimore Towson 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 3 Southerly Court # 402 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 🗶 No White δ Specify. 3 ☐ Widowed X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Colonel **USAF** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (Walter Henry Deale Eugenia Foreman Carrigan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 11836 Robertson Farm Circle Fairfax Virginia 22030 Thomas H Deale 20a. Method of Disposition
1 ☐ Burial 2 🛣 remation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State GreenMount Cemetery 5/25/06 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) nature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc unnes 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? LIVER FAILURE 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/2 No certificate 1 Tes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA nours after death. neret Director: After this / filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital o within 24 hours af To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 32. Registrar's Signature 31. Date filed State Registrar

State of Maryland / Department of Health and Mental Hygiene > Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ada Geneva Dasher 7:00 p. May 18, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Ellicott City Health & Rehab Center Howard If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F 95 Yrs. Director 219-30-5802 June 12, 1910 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show in than "natural", or items 23a or 28a-f show 1 Tyes 2 XNo Funeral Director Maryland Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21043 Was Decedent Ever in U.S. Armed Forces?

1 Yes 20 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. White 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Cosmetics Elementary/Secondary (0-12) College (1-4or 5+) Sales Consultant 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) d 2 should be fi th and Mental F Junie Gilmore Miller Ellen Minnie Wine and h 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If Item 27 is 5670 Waterloo Rd. Columbia, Maryland 21045 Ms. Geneva Sauder Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Purial 2 Cremation 3 Removal from State 5 Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 05/22/2006 Ellicott City, Maryland Good Shepherd Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBURN **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical the use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown 9 Unknown ٥. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 3 Probably 1 🗌 Yes 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has 1 Yes 1 Yes 2 🗌 No Division of Vital or Attending Physician: Be funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 Mo 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of Injury 28a. Date of Injury (Month, Day Year) Medical Certification; 27. Manner of Death 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. neral Director: / 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours a To the Funeral L To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) and address of person who completed cause of death (Item 23a) (Type, Print) BOR 25 31. Date filed (Month, Day, Year) MAY 2 3 Registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygiene 2 0 0 6 1 6 1 6 3

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			For State Registrar	State of N	Maryland	•	artment of F rtificate of		nd Me		giene Reg. No	2006	16161
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036	hours after death with the Marylar kurel', or Itama 23a or 28a-f show at Examicar mast be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force d 1 Yes 2 If Yes, Give Year or Dates	ş? I No	1	Was Decedent of Hif Yes, specify Cuba		in? (Specifi Puerto Ric	y Yes or No an, etc.)	-	14. Race - Ameri Black, White Specify: WHI	, etc.
9500-61212	within 72 ho iene. • than "natur ire Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 8		or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired NURSE	durina most o	of working			Cind of Business/Ir	ndustry
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,	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or content of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of	a. Due to (or a	ed the death line.		er the mode of dying	_		•			Approximate Interval Between Opset and Death
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Amend item#1,perfD, 2855,5/23/06 TI
State of Maryland / Department of Health and Mental Hygiene

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State Registrar 31. Date filed (Month, Pax Year) 3 2006

Sparke

32. Registrar's Signature

VOID

CERTIFICATE

2006-16/66

SEE

CERTIFICATE #

2006-18851

Perry J. Fancher

6/20/06 TT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 8.10PM **Physician** Oller 6 Clemen The 20 200 Male /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Ellicott City Howard Ellicott City Health & Rehab Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5 Social Security Number **Funeral** Days 1 □ M 2 F Months Director 176-22-9393 October 22, 1913 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State items 23a or 28a-f show the Mudical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Ellicott City Howard Maryland 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 21043 U.S.A. 8777 Frederick Rd Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No ō Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify Black 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. House Keeping Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental William H. Fuller Clementine Mosely P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 le 8777 Frederick Rd. Ellicott City, Maryland 21043 othar Ms. Essie Hammond Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State ţ ō Department of Important: If any injury or 4 □ Donation 5 □ Other (Specify) 05/27/2006 Ellicott City, Maryland Pine Orchard Cemetery 21. Sign of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tream Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Clerco Due to (or as a consequence of) Box 68760. physician the IF FEMALE ase. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year or in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. the a detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 3 Probably 4 Unknown 2 No 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: Hospital: Nursing Home 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3□ DOA 5 Residence 6 Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural
2 Accident 5 Pending investigation 2 □ No death. 1 Yes in by the Diractor: 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide within 24 hours a To the Funeral (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. icai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 13064

Registrar

State

109 Back

River Neckload

Balhonne

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

201-109

Kamesh Sabapally

31. Date filed (Month, Day,

			Stata	partment of Health and Nertificate of Death		2006	16168
	*	-	Registrer 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. 2. Date of Death		3. Time of Death
	Physicia /Medic	,	EDITH	FRIEDMAN	MAY 18		10:47 P M
}	Examin	er	4a. Facility Name (If not institution, give street and number) 6822 HUNTINGTON DRIVE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	4b. City, Town, or Location of Death BALTIMOR v) If Under 1 Year If Under 24 Hrs.			TIMORE
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 178–22–1169 76 Yrs.	Months Days Hours Min.	8. Date of Birth Month Day Ye 05/22/1	929	PA
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
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	ns 23	Funeral	6822 HUNTINGTON DRIVE 11. Marital Status 12. Was Decedent Ever in U.S. 13	21207 B. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	
920	2 should be illed within 72 hours after death with the Maryland and Mental Hygiene. Is marked othar than "natural", or Items 23a or 28a-f show aumatic avent, the Medical Evantamental Leaneithed at	þ	Armed Forces? 1 ☐ Never Married 2 ☐ Married	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White Specify:	, etc. WHITE
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<u> </u>	should I	ဥ	MORRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rui	ral Route Number C	ity or Town State 7	SEI FRET
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more,	0 O	1	1 X Burial 2 Cremation 3 Removal from State	ematory or other place) PARK		c. Location - City or T	
altim				ALOM MEMORIAL 05/ 22. Name and Address of Facility S0	19/2006		STOWN, MD
Ba	permit. Departn Imports any inju			8900 REISTERSTOWN			
ī			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final	-	-		Approximate Interval Between Onset and Death
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Ф.	uires that the disigned by the	by Physiclan/Me	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
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Division of	after d Diract	Certification;	4 Homicide determined determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rui State)	al Route Number,
	To the Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, de 2 Madical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	29c. License number	/ 29d.	Date signed (Month)	Day, Year)
•	nĎ		30. Name and ordress of person who completed cause of death (Item 23a) (Type	e. Print)		5 / / 2	6
	7		10755 Falls Rd. #200 (cutherville n	no 21	093	
4	Sta Regist		31, Date filed (Month, Day, Year) 32. Registrar's Signature				
			MAIN				

				State of Maryl	and / Depa		lealth and I	Mental Hygi	•	16169
	Physici		Decedent's Name (First, Middle, Last) LORRAINE	E R		FRIEDM		2. Date of Death May 19	Day Year	3. Time of Death 6:25 P M
	/Medio Examin	1 4	4a. Facility Name (If not institution, give st CHERRYWOOD FUTU	URE CARE				RSTOWN	4c. County of De	ALTIMORE
	Funeral Director		5. Social Security Number 6. Sex 205-14-5597		vrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day 02/04/1	(925)9. B	inthplace (State or Foreign Country) PA
	death with the Maryland ims 23a or 28a-f show if trust be ricilling at	Director	10a. State 10b. County MD BALTIN		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	23a or 2	al Dire	10e. Street and Number 211 FOX HAVEN COUF	RT		10f. Zip Code	21136	10	g. Citizen of What C	Country? USA
9036	be filed within 72 hours after death with the Marylan na Hygiene. of other than "natural", or itema 23a or 28a-f show event, the Medical Exactions or neat be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 M Widowed 4 Divorced	Was Decedent Ever Armed Forces? □ Yes 2 ☑ No If Yes, Give Year or Dates:	n U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🏋 No		pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	filed within 72 hours after Hygiene. sther then "natural", or ite ent, the Medical Erabilitie	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Dece (Give life. HOMEM	dent's Usual Occup kind of work done DO NOT use retire 1AKER	pation during most of word)	king	6b. Kind of Busines	s/Industry
yland		To Be C	17. Father's Name (First, Middle, Last) ABRAHAM		ROBKI		ESTHER		UNOBTAINA	
	nd 2 still ar		19a. Informant's Name/Relationship (Type BARBARA NELSON / [DAUGHTER	211	FOX HAVE	N COURT -	REISTERS	STOWN, MD	21136
Baltimore,	permit. Pages 1 al Department of Hea Important: If Item any injury or othe		20a. Method of Disposition 1			osition (Name of matory or other pla EREIN LOI		Date 2	oc. Location - City o	
Balt	permit. Departr Imports any inju		21. Signature of property species License	θ		2. Name and Addre		L LEVINSO		., INC.
*	Pnysician /Medical		23a. Part 1. Enter the disease, or complic shock, or beart failure. List only one immediate Cruse (Final disease or condition resulting in death)		gron	ter the mode of dyii	ng, such as cardiac	or respiratory arres	st.	Approximate Interval Between
760, 1	Examiner and springly transit be executed e purial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con Due to (or as a con	saquanea of).					
.O. Box 68	The law requires that the death certifica tite has been signed by the attending ph. page 2 should be detached for use as th	by Physician/Medi	IF FEMALE: 23 b. Was decedent pregnant in the past 12 gronths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pre 1 Live birth 2 If 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnanc	у		23d. Date of di Month	alivery Day Year
₽.	quires that in signed b uld be detz	ed by Pl	Part II. Other significant conditions conf	thibuting to death but not	resulting in the L	underlying cause give	ven in Part I. JUNA		acco use contribute 2 No 3 F	to the cause of death? Probably 4 (1) Onknown
al Records,		Completed							ed? prior to death?	autopsy findings available completion of cause of
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury	of 28c. Injui	ner: 4 ursing H	ome 5 Residen 28d. Describe how	ce 6 □Other (Sp	ecify)
DİXÏ	ital or Att urs after d ral Direct		4 Homicide determined	28e. Place of Injury - / building, etc. (Sp	ecify)			City or Town,	State)	Rural Route Number.
	To the Hospital of within 24 hours at To the Funeral D completely filled it	Medical	(Check only 2 Medical Examin	ician: To the best of my r: On the basis of exar and manner stated.	knowledge, deat nination and/or in	ivestigation, in my o	opinion, death occu	rred at the time, dat	e and place, and du	ue to the cause(s)
	vitt	~	29b. Signature and title of certifier			29c. Licens			d. Date signed (Mor	
	1		30. Name and address of set set who cor	Hett	Conti	Print)	38 G	reene	Ties ,	106 Ref 21208
10 M	Sta Regist		31. Date filed (Month, Day, Year) MAY 2. 3 2006	32. Registrar's S	ignature					0

06-03250 Justin Fisher

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0555 hrs May 14, 2006 Medical Examiner Justin Fisher c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Director 11-10-87 Country) MD 214-19-3932 18 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location any 10a. State 10b. County 1 Yes 2 X No 28a-f show Anne Arundel Glen Burnie permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the <u>Medical Examiner must be notified</u> at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Old Stage Rd 21061 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. 1 X Never Married 2 Married 2 X No Yes White Yes 2 X No specify: Specify. 3 Widowed 4 Divorced ۾ 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ timore, MD 21215-0036 12 1 Student Salisbury State University 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Janice Clark Dennis Fisher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 7 Old Stage Rd, Glen Burnie, MD Janice Fisher Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State crematory or other place) Glen Haven Cemetery 5-19-06 Glen Burnie, MD Oongtion 5 Other Spe at we properly Screen 4 Donation 5 ²²Flame and Address of Facility Funeral Home 426 Crain Hwy S, Glen Burnie, MD ryOFink MO1148 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Home Historical Co. #166, Records, P.O. Box 68760, 1. The law requires that the death certificate be executed Due to (or as a consequence of): events resulting in death) Last and trans. Physician/Medical item#16b,perFH,G856,6/1/06 TI AMENDED signed by the attending physician is be detached for use as the burial -UNPENDED IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed has been s e 2 should l 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? . death? 1 🗸 Yes After this certificate ✓ Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Other / DOA Nursing Home 5 Residence 6 1 V Yes 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 8c. Injury at Work? 28d. Describe how injury occurred Certification: May 14, 2006 Subject shot by police 0431 hrs Natural 1 Yes 2 ✔ No death. Director: d in by the f 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City hours after Could not be Suicide 24 hours a (Specify) Street Park and Roland Roads, Pasedena, MD 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical within 2 To the F 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E May 15, 2006 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) MAY 2 32. Redistrar's Signature State Registra

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			For State Registrar	State of Ma	ryland / Depa	artmen rtificat			ind Me		iene	91 5 16.		6171
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			Joseph Ritchey	Hospice			Balt:	imore					N/A	
	Funeral Director		214-30-7234	ex 7. Age	(In yrs. last birthday) 58 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Pay, [ar. 4,	1948	9. Bir Ge		tate or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation							10d Insi	de City Limits
	lary!	5	MD N/A	Δ.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		timo	ro						Yes 2 No
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	with	ã	838 N. Eutaw S	troot		101. 21		21201						
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an	td be ental ked c	To B	Alan Greene					I	ottio	Plack				
Maryland	shou mar mar	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address	(Street a			Route Number,	City or Tox	wn. State.	Zin Code)	
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<u>5</u>	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic angoce.		20a. Method of Disposition		20b. Place of Dispo				Dat		20c. Locatio			
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ന	icate be executed physician and s the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):									
Box 6	# 00 to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	Ectopic pr						Date of dea	livery Day	Year
P.O.		ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	5 C) Other (3p	0011J/							
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8	w re	jete	thrombourt	minim			I			24a. Was an	24	h Were au	ttonsy find	ings available
al Re	n: The la ificate has or, page 2	e Completed	25. Was case referred to medical	, exite						autopsy perform 1 Yes 2	ed? No	prior to death?	completion	of cause of
5	sicie ; cert irect	œ	examiner? 1 Yes 2 No	Hospital:	nt 2 ER/Outpatien		Othe			Check only one	•		IA	m . h = F
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Divis	tel or Atte s after des al Directo ed in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, stre (Specify)	eet, factory	, office		28f	f. Location (Str. City or Town,	eet and Nui State)	mber or Ru	ural Route	Number,
	the Hospi	Medical	(Check only 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination and/or inv	estigation,	in my opi	nion, death	place, and occurred	d due to the ca at the time, da	use(s) and te and plac	manner as e, and due	stated.	se(s)
	To To	2	29b. Signature and title of certifier	111	40	29c	. License	number		29	d. Date sign	ned (Monti	h, Day, Ye	ar)
	n		West 1.	Maiden	de in		DY	7105			5/	4/06	5	
	C		30. Name and address of person who	com seted cause of de	ath (tem 23a) (Type, I	Print)						1		
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	/Medica Examine		4a. Facility Name (If not institution			4b. City	Town, or	Location of Deat	h	4c. Cou	nty of Death	1
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F	uneral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last bii	thday) If Unde	r 1 Year	If Under 24 Hrs Hours Min.		th		place (State or For
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and	>	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City Lin
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s 1 a	Item othe		20a. Method of Disposition	- 5-	cemete	f Disposition (Na ry, crematory or	me of other plac	ce)	Date	20c. Location	on - City or To	own, State
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	S).		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that cause t only one cause on each	d the death. Do line.	not enter the mo	de of dyin	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
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The law requires that the death certifical	attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d.	Date of deliv	егу
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Physiclen:	ø :ē	2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpat				4 Nursing			ther (Speci	Assisted Living
ng P			27. Manner of Death 1 ☐Natural 5 ☐ Pendi	28a. Date of Inj (Month, D	ay Year) 28b.		28c. Injury Work		28d. Describe	how injury oc	curred	
Attending	tor: A	cati	2 Accident invest 3 Suicide 6 Could	igation		M		Yes 2 □ No	29f Location /	Stroot and No	mbor or Rue	al Route Number.
l or Attending	Direct in by	Certification:			njury - At home, f etc. <i>(Specify)</i>	arm, street, racto	гу, опісе		City or To		INDELOT AUT	ar noute rumber,
ospital	eral I	Ce	29a. Certifier 1 ☐ Certify	ing Physician: To the bes	t of my knowledg	e death occurre	d at the tin	me, date and place	e, and due to the	cause(s) and	l manner as s	stated.
Hos Po	To the Funeral Director:	Medical	(Check only 2 Madica one)	I Examiner: On the basis and manner s	of examination a	nd/or investigation	n, in my o	ppinion, death occ	urred at the time,	date and pla	ce, and due t	o the cause(s)
o the	o the	Me	29b. Signature and title of certifi			25	9c. Licens	se number		29d. Date si	gned (Month,	Day, Year)
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	V		30. Name and address of person	who completed cause of	death (Item 23a)	(Type, Print)		. ~	.0.	_	11 -1	16,
	N		30. Name and address of person	Q (2) B	+ 0	Soc.	500	46 3	00, VI.K	esu	1110	Marlo

State Registrar

31. Date filed (Month, Day, Year)
MAY 2 3 2006

32, Registrar's Signature

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			For State Registrar	ricasc			d / Depa	artment of rtificate o	Health	and Me	ental Hyg	jienę	06	16173
× 5				ne (First, Middle, La	st)						2. Date of Dea Month		Vans	3. Time of Death
, E	Physici /Medi			ndonov Geo				1	<u> </u>		05		2006	
	Examir			(If not institution, given		nber) OSPIT	-Δ.)	4b. City, Towr					nty of Death	
	A. 2.	\$2 .	5. Social Security	AMARIT Number 6.5		7. Age (In yrs.			TIMO		8 Date of Birth	Not	App I	icable place (State or Foreign
	Funeral Director		None Usual Residence		12 M 2□F	72	Yrs.	Months Day		Mín.	8. Date of Birth (Month, Day June 19	1933	Bei	iliskar, Bulgaria
	land ow		10a. State	10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
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Maryland	ould be t Mental h arked of	Be		oimenov G						_	zarova	_	•	
7	2 should and Me is mark	2		lame/Relationship			19b. Maili	ng Address (Stre						ip Code)
	nd 2:		Mr. Bori	slav Geor	giev (Son)	129	E. Timo:	nium Ro	oad	Timoni	um,Mar	ryland	d,USA 21093
Je,	of Health item 27		20a. Method of Di	sposition Cremation 3	70	20b. F	Place of Disposemetery, cre	osition (Name of matory or other p	olace)	Da	ate	20c. Locatio	n - City or T	own, State
Ĕ	Page nent c int: If			oremation 3 t 5 ☐ Other (Speci		Eva	ns Fun	eral Ch	apel 🏻 l	May 2	3,2006	Forest	Hill	,Maryland
Baltimore,	permit. Pages Department of I Important: If its any Injury or or anse.		21. Signature of F	uneral Service Lice	nsee a	17. A	Pě	aceful Ad	ATterna	ative	s Funer	al&Cre	ematic	on Ctr.,P.A
	005 * 0			per	J. Jo								I,USA	Approximate
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	/Medical Examiner		resulting in death			or as a conseq	uence of):							
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ς,	tificate be executed ig physician and as the burial-transit	Exai	resulting in death)	Last		or as a conseq			1 (0 0)					
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68	certificat nding phy use as the	Med	IE EELANE.											
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P.O.	that i	4	Part II. Other sign	ificant conditions	contributing to de	eath but not res	ulting in the u	inderlying cause	given in Part I	l.	23e. Did to	bacco use co	ontribute to	the cause of death?
rds	quires n sign	D D	CARC	INOMATO	SIS						1 🗆 Y	es 2⊞No	3 ☐ Pro	bably 4 Unknown
Records,	The law requires that the tite has been signed by this bage 2 should be deteche	olete	OMEN	TAL ME	ESS IN	THE	ART	OMEN			24a. Was a		o. Were aut	opsy findings available
R	sician: The law certificate hes t irector, page 2 s	E									autops perfor	med?	death?	ompletion of cause of 2 No
ital	lan: rriffica stor. p	Be C	25. Was case reference	erred to medical					26. Place	e of Death	Check only or	18/		
<u>></u>	Physician: this certificantal director.	2	1 ☐ Yes 2€					IL 3 DOA			e 5 Resid			(fy)
n c	Ing P	on:	27. Manner of Dea 1 ⊟Natural	5 Pending		of Injury th, Day Year)	28b. Time o		vork?		8d. Describe h	ow injury occ	urred	
isio	death death stor: /	icat	2 ☐ Accident 3 ☐ Suicíde	investigation 6 Could not i	oe Zee Blace	of Injune . At h	ome farm st	M 1	Yes 2		8f Location /S	treet and Nur	mber or Au	ral Route Number,
Division of Vital	after Direction by	Certification:	4 Homicide	determined		ng, etc. (Specif		root, ractory, one	,,		City or Town			a. Floato Wallison,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	Medical C	29a. Certifier (Check only one)	1 ☐ Cartifying ₽ 2 ☐ Medical Exa	miner: On the b									
	To the	Σ	29b. Signature an						ense number			9d. Date sign	,	
	1		PK.S	shibit	NOU M!	1)		KE	5000			05/2	1/200	06
	17		30. Name and add	tress of person who	completed caus	of death (Item	0 (HP)	Print) AUEN B	QW.	BALT	IMORE	M	D-21	239
11	Str	ate	31. Date filed (Mo			gistrar's Signa		2		-	-		-	-

DHMH 17 Rev 1/2001

Registrar

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			For State Registrar		State o	f Maryl	and			nt of H			Mental H	ygien		06	16174	3
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- Bel	Funeral Director		5. Social Security Number 213-03-3006 Usual Residence of Deceden	6. Se		Z. Age (In) 86	rs. lasi		If Und Months	er 1 Year Days		er 24 Hrs.				1	lace (State or Foreig	מון
the Maryland	r 28a-f ahow	Director	10a. State 10b. Con		re			own or Lo		ip Code				10g. Ci	tizen of	What Coun	0d. Inside City Limits 1 ☐ Yes 2 No.	
5-0036 72 hours after death with the Maryland	iene. rihen "natural", or iteme 23e or 28e-f ahow Ite Medical Examiner must be notified at	by Funeral D	8548 Oakleigh 11. Marital Status 1 Never Married 2	Married	12. Was Dece Armed Fo 1 Tyes If Yes, Giv Year or Di	rces? 2 No	n U.S.		Was Dec	ecify Cubai	spanic C n, Mexic Specif	an, Puert	pecify Yes or No Rican, etc.)	USA	14. Ra Bla	ice - Americack, White, e	an Indian,	
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Baltimore,	Department of I		4 Donation 5 Othe	r (Specify)		hes		. Name a		s of Faci	lity unera	2006 1 Altern	nativ	es		aryland	
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ecords,	has been signed by the atte ge 2 should be detached for	Completed by Pr	Part II. Other significant con-	ditions co	ntributing to de	eath but not	resultin	g in the ur	A C	Cause give	n in Part	1.	1 24a. Was	Yes 2	□ No	3 Proba	bly 4 Unknown sy findings available pletion of cause of	_
Vital Residents The	certificate has irector, page 2	Be	25. Was case referred to medexaminer?	-	Hospital:					Othor	_		1 ☐ Yes				2 No	
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Divi	within 24 hours after death. To the Funerel Director: After completely filled in by the funer.		4 ☐ Homicide det	emined	28e. Place buildin	of Injury - A	ecify)				- dato a	ad place	28f. Location (City or To	wn, State)			
To the Hospitel	within 24 h To the Fur completely	Medicai	(Check only 2 ☐ Medione) 2 ☐ Medione) 29b. Signature and title of cer	cal Exam	ner: On the ba and mann	isis of exam	ination	and/or inv	estigation	c. License	nion, de	ath occur	red at the time,	date and	place,	anner as sta and due to t d (Month, D	he cause(s)	
)			30. Name and address of pers	Son who co	Un ompleted cause	M)	23 tem 23	a) (Type, I	Print)	00	062	259	14	5	12	0/0	6	
to the second	Sta Registr	te	NASHAT 31. Date filed (Month, Day, Ye	A	JA LL 32. Re	A- egistrar's Sig	Gnature	-ood	Sor	nari	ten	Hoy	pital			-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 4a 10c 19h per doc & fh 8856 6-6-06 vt Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 5.50PM CHESTER MAY 2006 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALTIMORE 3110 Cresson Avenue Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

June 15, 19 5. Social Security Number Birthplace (State or Foreign Country) Sex 14 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months 90 Yrs 1915 Reisterstown, MD Director 705-10-5811 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Director Baltimore Hebbville 10e. Street and Number Cresson 10f. Zip Code 10g. Citizen of What Country? 3110 Crosson Avenue items 23a USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 12 should be filed within 72 hours after a nad Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify <u>A</u> 3 XWidowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore Elementary/Secondary (0-12) College (1-4or 5+) Transit Association Carpenter 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Peges 1 and 2 should be Depertment of Heelth and Mental Important: If Item 27 Is marked any injury or other treumatic events. Ida Virginia Bobbletts Lewis Edward Gill 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21227 144 First Avenue, Landsdowne, Md Robert V. Baker, Sr. (Stepson) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/20/06 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery Woodlawn, MD 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road, Randallstown, MD 21. Signature of Funeral Service Lipensee dlinor Moo 333 21133 23a. Rent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIOMYOPATH Immediate Cause (Final disease or condition resulting in death) IS CHEMIC Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed ettending physician and for use es the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical use es IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 should be 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No. Completed Deed 24b. Were autopsy findings available prior to completion of cause of death? hes director, page 2 autopsy performed? certificate 20 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check on yone Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Tes -2 TYNO 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. filled in by the fu 2 Accident 1 Tyes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or At within 24 hours after or To the Funeral Directompletely filled in by 4 \(\) Homicide 1 Certifying Physician: To the hest of my knowledge, death convict at the time date and block and due to the nause(s) and memors stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person no completed cause of death (Item 23a) (Type, Print) 0 OLD COURT NOAD, MD, 21173 400 31. Date filed (Month, Day, Year) 32/Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

2006

			1 - For State Registrar	State of N	Maryland / I	Department <i>Certificate</i>				giene 006	16176
	Physici	an	Decedent's Name (First, Middle, L						2. Date of Dea Month	th Day 2000	3. Time of Death 9:45 Am
	/Medic Examir	_	Margaret L 4a. Facility Name (If not institution, g			4b. City, 1	Town, or Loc	cation of Death	1.107	4c. County of Deat	
			Union Memorial				Baltin			N/A	
	Funeral Director		5. Social Security Number 247–32–7644	Sex 7.7 1 ☐ M 2 ☑ F	Age (In yrs. last bi 87	rthday) If Under 'Months Yrs.		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day Feb. 24	Year) 919 9. Birt	hplace (State or Foreign untry)
	D		Usual Residence of Decedent 10a. State 10b. County		10- 0- T-					Sou	th Carolina
	danyla f ehov	ŏ	Maryland N/.	A	10c. City, Tow	altimore					10d. Inside City Limits YXYes 2 ☐ No
	r 28a-	Irect	10e. Street and Number			10f. Zip	Code			10g. Citizen of What Co	untry?
	ath with	aiD	1021 West 37	th Street			21211			USA	
036	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 ie marked other then "natural", or Iteme 23a or 28a-f ehow empt injury or other traumatic event, the Modical Examinar roual be notified at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	s? ∄No	13. Was Decede If Yes, speci		nic Origin? (Spe lexican, Puerto F pecify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
5-0	72 ho	eted	15. Decedent's (Specify only highest g		16a	. Decedent's Usual (Give kind of work	done durin	n ng most of workir	ng	16b. Kind of Business/	Industry
12	within then then	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Homemal				Own Ho	ne.
p	al Hyg	Be C	17. Father's Name (First, Middle, Las							Maiden Sumame)	
yla	Ment Ment Marked Marked	5	Lee Andy Whit					Mary Be			
e, Maryland 21215-0036	and 2 sh feelth and m 27 te m her traum		19a. Informant's Name/Relationship Bonnie Scott	Daught	er	10 Sono	ora Dr	rive Pa	sadena,	r, City or Town, State, 2 MD 21122	
Baltimore,	it. Pages 1 artment of H artment: If Ite injury or ot		20a. Method of Disposition ↑ Durial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	ify)	cemete	f Disposition (Namery, crematory or other). More Nat:	ional	5/23/	2006	Baltimore,	Maryland
Ba	Depa Impo eny I		Duym L	3. Hens	12)	Burgee-	Henss	s-Seitz Road Ba	Funeral	Home, Inc	. 21211
	Physician /Medical Examiner pus- pus- pus- pus- pus- pus- pus- pus-	Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List only mediate Cause (Final disease or condition resulting in death) 5 aquantiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	a. COVO Due to (or a Due (o a	ed the death. Do line. Sa consequence as a consequence as a consequence as a consequence	Arten		och as cardiac or		est,	Approximate Interval Between Onset and Death
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	uires thet the de n signed by the a ld be detached f	þ	Part II. Other significant conditions	contributing to death	but not resulting i	n the underlying car	use given in	Part I.	23e. Did tol	pacco use contribute to	the cause of death?
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Ĭ Ĭ	ysiclan: Th is certiticete director, pag	Be	25. Was case referred to medical examiner?	Hospital:		./	Other	Place of Death		100	
Division of Vital	ding Ph After th tuneral	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of In (Month, D	jury 28b.	Itime of njury M	c. Injury at Work?	2		ence 6 Other (Spec ow injury occurred	n(y)
Si Oi N	tal or Attenciss etter death al Director: ed in by the	Certific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of I	njury - At home, fa etc. <i>(Specify)</i>	ırm, street, factory,	office	2	8I. Location (St City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospital or Attentwithin 24 hours etter deatl To the Funeral Director: completely tilled in by the	Medicai	29a. Certifier 1 Certifying F 2 Medical Ext	hysician: To the besiminer: On the basis and manner s	of examination an	e, death occurred at dvor investigation, i	t the time, da n my opinior	ate and place, as n, death occurre	nd due to the ca d at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
)	With com	Σ	29b. Signature and title of certifier				License nur	3539	2	9d. Date signed (Month	Day, Year) 1, 2006
6			30. Name and address of person who	1 It (41)	U	(Type, Print)	emory	al Hes	oital	Bultimore	, 11)
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			State of Maryland / Departme	ent of Health and Me	-	_	16177
			Registrar	ate of Death		. No.	
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) Pearl K. Godack		2. Date of Death Month	Day Year	3. Time of Death 2159 PM
	Examin			ty, Town, or Location of Death Baltimore		4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. Sex 1 7. Age (In yrs. last birthday) If Unit Month	der 1 Year If Under 24 Hrs. ns Days Hours Min.	8. Date of Birth Month, Day, Y DeC. 19,		hplace (State or Foreign untry) Aryland
	p ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. fnside City Limits
	a Maryla a-f shov	ctor	MD Baltimore Middle R:	iver			1 ☐ Yes 2 🛣 No
	3s or 28	i Director		Zip Code 21220	10g	. Citizen of What Co USA	untry?
	deati	Jer.	11. Maritaf Status 12. Was Decedent Ever in U.S. 13. Was Dec	cedent of Hispanic Origin? (Spe- pecify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Ame	
39	within 72 hours after death with the Maryland ene. then "naturei", or items 23e or 28e-f show La Medical Exami in must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo	pecify Cuban, Mexican, Puerto F : 2 ∑ No <i>Specify:</i>	ican, etc.)	Specify: W]	nite
15-0	"natur	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of light DO NOI)	sual Occupation work done during most of workin Tuse retired)	16	b. Kind of Business/	Industry
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Maryland 21215-0036	ges 1 end 2 should be filed within 72 hours after death with the Marylar It of Health and Mental Hygene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at	To Be Co	17. Father's Name (First, Middle, Last) Grant Lewis	18. Mother's Name Gladys	(First, Middle, Ma		
Mary	d 2 shou th and M 7 is mar traumati	-		ess (Street and Number or Rural			Zip Code) 220
Baltimore,	permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygene. Important: If item 27 is marked other than any injury or other traumatic event, than Means in the Means one.		20a. Method of Disposition 1 🗷 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Name of D	ate 20	c. Location - City or Baltimore	
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	Physician /Medical		Immediate Cause (Final disease or condition a. HYPOVOLEMIC SHOCK resulting in death)				Onset and Death
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Φ.	The law requires that the site by the best been signed by the bage 2 should be detache	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlyin	g cause given in Part I.			the cause of death?
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<u>=</u>	n: Tł ficete nr, pa	ပိ	25. Was case referred to medical		1 ☐ Yes 2 【	ZNo 1 ☐ Yes	2□ No
Ξ	Phyaiclan: this certific rat director,	00	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death Other: 4 Nursing Horn		6 COther (C-1	-14.)
on of	ding Phy. h. After this funerat d	tion: To	27. Manner of Death 1 Manual 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) (Month, Day Year) M		8d. Describe how		city)
Division	l or Attanding after death. Director: After	Certification:	3 Suicide 6 Could not be determined 28e. Place of fnjury - At home, farm, street, fact building, etc. (Specify)	tory, office 2	8f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurr (Check only one) 1 Medical Examiner: On the basis of examination and/or investigation and manner stated.				
	To the within 2 To the comple	Me		29c. License number	290	. Date signed (Monti	h, Day, Year)
	->-0		b cyanagner mo	AT 2438946	N	1A4 16 20	006
	8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
	Sta		CATHERINE GALLAGHER MD UNION MEMORIA 31. Date filed (Month, Day, Year) MAY 2 3 2006 MAY 2 3 2006	L HOSPITAL MD			
	Regist	ar	MAY 2 3 2006 Acres 13 1900				

			For 1 _ State		-		and / Depa		t of H	ealth a	and M	lental Hy	giene	200	6	16179
			Registrar	della Landi			Ce	lineare	- OI L	Jeani		2. Date of De	Reg. No.			3. Time of Death
*	Physici /Medio	- 100	1. Decedent's Name (First, Mic Pramila Gan	ı								Month May 21	, 20	06	Year	11:03P M
	Examir	ner	4a. Facility Name (If not institu	tion, give st	reet and nur	mber)		4b. City,	Town, or	Location of	of Death			County o		
		V.	11300 Palat	ine Di	rive	7 Ago (In)	yrs. last birthday)	Pot If Under	omac	If Under	24 Hrs	8. Date of Bir		lontg		
	Funeral		5. Social Security Number		м 2(Х) г		85 Yrs.	Months		Hours	Min.	June 1	v. Year)	020	Indi	place (State or Foreign
	Director		N/A Usual Residence of Decedent				ره					June 1	J, 1	920	Indi	.a
	ehow		10a. State 10b. Cou	nty		10c	. City, Town or Lo	cation							1	10d. Inside City Limits
	Man	to	Maryland Mon	tgomeı	rv	Р	otomac									1 ☐ Yes 2 XNo
	r 28s	Director	10e. Street and Number	- Bome			o coma c	10f. Zip	Code				10g. Cit	zen of WI	nat Cour	ntry?
	h wit	ai D	11300 Palatin	e Driv	ve.			20	854				Ind	ia		
	deat	Funeral	11. Marital Status		2. Was Dece Armed Fo	edent Ever	in U.S. 13.			ispanic Ori	igin? (Sp	ecify Yes or No Rican, etc.))-		- Americ , White,	ean Indian,
9	or ite	F	1 Never Married 2 N		1 ☐ Yes If Yes, Giv			1 ☐ Yes 2						Specify:	, remo,	010.
003	Junei',	d by	3 ☑ Widowed 4 ☐ Divore		Year or D	ates:									Asi	
21215-0036	within 72 hours after death with the Maryland ane then "natural", or items 23e or 28s-1 show the Medical Exeminar must be notified at	Completed	15. Dece (Specify only hig	lent's Educa hes <i>t grad</i> e			(Give	dent's Usua kind of wor DO NOT us	rk done d	during mos	st of work	ing	16b. K	nd of Bus	ine <i>s</i> s/In	dustry
121	within ne. then	d m	Elementary/Secondary (0-1:	2)	College (1	1-4or 5+)		maker)			1000	n Hor	m 0	
	Hygie ther ant,	ပိ	17. Father's Name (First, Midd	lle. Last)			110406	maker.		18. Mothe	er's Name	e (First, Middle				
Maryland	2 should be filed withir and Mental Hygiene. ie marked other than aumatic event, lite M	9 Be								Ψa	i To	glekar				
2	should ind Men marke umatic	2	Anna Jogleka 19a. Informant's Name/Relati	_	e, Print)		19b. Maili	na Address	(Street a	Appropriate to the last special or	Application of the second	giekai al Route Numb	er, City o	r Town, S	tate, Zip	Code)
≥	nd 2 s lith ar 27 ie r trau		Sona Bhatnag			ohter						Potoma	_			
<u>ة</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itame 23e or 28a-4 show amportant: if item 27 is marked other than "natural", or itame 23e or 28a-4 show amy injury or other traumatic event, the Medical Examinar must be notified at QRGS.		20a. Method of Disposition			20	b. Place of Dispo	osition (Nan	ne of	(a)	May					own, State
n O	ages ant of it: if i		1 ☐ Burial 2 🏋 Crematic 4 ☐ Donation 5 ☐ Other	on 3 □Re	moval from	State	b. Place of Disponential Contgome	ry	uner prac	9)			D = +1		М.	1
Baltimore,	artme ortan injur		21. Signature of Furieral Serv	-	Э		Cremator 2	Lum, 2. Name an	d Addres	s of Facili	2006 v Ro	bert A.	Pum	nesqa phre	v Fu	aryland meral Home
Ba	Depa Impo Impo Any i) remil	CI	nu	. M	00803 Be	thesd	la-Ch	nevy	Chas	e, Inc.	.755	7 W1:	scon	neral Home, sin Avenue
			23a. Part1. Enter the disease shock, or heart failure.	, or complic	ations that	Leed the	death. Do not en	ter the mode	e of dyin	g, such as	cardiac	or respiratory a	rrest,			Approximate
	Dhysician		Immediate Cause (Final	ist only one												Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a.			ory Arre	est								
	Examiner						clerotic	Card	li ove	ecu1	ar D	icasca				
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oʻ.	le be executed ysician and e burial-transit	Exa	resulting in death) Last	Ŭ.	Due to	(or as a con	sequence of):									
760,	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	cai		d.											_	
89	death certifica le attending phi ed for use as th	Physician/Medi											- 1			
Вох	h cer endin	N/N	IF FEMALE: 23b. Was decedent pregnant	23	ic. If yes, out			Ectopic pr	ennancy					23d. Date		*
	deat	Sicie	in the past 12 months? 1 □ Yes 2 🌠 No			nant at time		Other (sp.					- 1	Mont	th	Day Year
P.0	at the by the	hy	9 Unknown							_		-	_			
	as On On	by	Part II. Other significant con-	ditions cont	ributing to d	eath but not	t resulting in the t	inderlying ca	ause givi	en in Part I	I.					he cause of death?
ord	w require been si should b	ted										1	Yes 2	X No	B [] Prob	pably 4 □Unknown
Records,		Completed										24a. Was	DSV	Dr	ere auto	ppsy findings available impletion of cause of
	The ate h	E O										perfo	rmed? 2 X No	de 1 (ath?	2 No
ita	artific ctor,	Be (25. Was case referred to med examiner?	lical						26. Place	e of Deat	h Check only	one)			
Ť.	Physician: this certific ral director,	2	1 ☐ Yes 2 ▼No	Ho	ospital:	Inpatient	2 🗆 ER/Outpatie			4 🗆 NI	ursing Ho	me 5 Resi	dence	6 Other	(Specif	٤)
0	ng P		27. Manner of Death 1 XNatural 5 ☐ Per	ndina	28a. Date (Mon	of Injury th, Day Yea	28b. Time of Injury		8c. Injun Worl			28d. Describe	how inju	y occurre	d	
Division of Vital	Attending r death. ector: After by the fune	Certification:	2 Accident inv	estigation uld not be			1	М		Yes 2 🗌	No					
Ξ	or Ati	i i		ermined	28e. Place build	of Injury - ing, etc. (St	At home, farm, st pecify)	reet, factory	, office			28f. Location (City or To	Street an wn, State	d Numbe)	r or Rura	al Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2															
	Hosp 4 hos Fune fely fi	Medical	(Check only 2 Medi	fying Physi cal Examin	er: On the b	asis of exar	knowledge, dea mination and/or in	th occurred ivestigation,	at the tin , in my o	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	date and	and man i place, ar	ner as s nd due to	tated. o the cause(s)
	the the	Med	one) 29b. Signature and title of cer	Mier	and man	ner stated.		290	Licensi	e number			29d Da	e sinned	(Month	Day, Year)
	Z × O		Los. Signature and three of cer	OI				250								
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10			30. Name and address of per							ъ .		V 1		000-	,	
	endanci a	0,0	Sona Bhatna 31. Date filed (Month, Day, Yo			11300 ∰gistrar's S	Palatir Gionature	e Dri	ve,	Poto	mac,	Maryla	nd	20854	+	
100	St Regist	ate rar	MAY 2	,		Maria -	M. A	medis	,							
		$\mathcal{L}_{\mathcal{L}_{3}}$	31711 2	~ 600	U MAR	A Sept Comment	100	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 19, 2006 10:00 PM Samuel Stewart Harrington 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Baltimore Gilcrest Hospice If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day 28, 1928 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours Min **X**□M 2□F Maryland Yrs. 559-48-4299 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Essex Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21222 1258 Sugarwood Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 13 Armed Forces? 12 Yes 2 No 10-9-50 14. Race - American Indian, Black, White, etc. 11. Marital Status X Never Married 2 Married White 1 Tes 2 No If Yes, Give Year or Dates: 8-5-54 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry **Metal** Elementary/Secondary (0-12) College (1-4or 5+) Fabrication 12 Accountant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lillian Estelle Young Howard James Harrington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3805 Patapsco Avenue, Violetville, MD 21229 James N. Smith - Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition Burial 2 Cremation 3 Removal from State Loudon Park Cemetery | 5-24-2006 Baltimore, MD 4 ☐ popation 5 ☐ Other (Specify) of Eumeral Sen 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) marths Metastatic carcinoma Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an diovasculai autopsy performed? res 25 No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

2

Funeral

Director

other traumatic event, the Medical Exertine must be notified at

"natural",

1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than '

permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any in ury or other trac

tha Maryland

72 hours after

21215-0036

Maryland

Baltimore

P.O. Box 68760,

Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be axecuted s been signed by t should be detach certificate tha funeral within 24 hours after death. To the Funeral Director: A

Examiner Physiclan/Medical Completed by Be Certification: To completely filled in by Medical

9 Unknown 25. Was case referred to medical examiner?

4 T Homicide

29a. Certifier

1 Yes 2 No 27 Manner of Death 1 Natural 2 Accident 5 Pending 3 Suicide

Hospital: 1 ☐ Inpatient investigation Could not be

determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

28a. Date of Injury (Month, Day Year)

29c. License number 2564

10NSON

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

3ET DOA

29d. Date signed (Month, Day, Year)

200 b

Location (Street and Number or Rural Route Number, City or Town, State)

tospice

1 Yes

Other: 4 Nursing Home 5 Residence 6 other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

completed cause of death (Item 23a) (Type, Print) aulkner WD

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

ot

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

Division of Vital Records, P.O. Box 68760,

	Pleas	se Type or	Print i	in Blac	k Ind	delible	ınk.	Ensu	ıre Al	II Copie	es Aı	re Legi	ble.			
For Stete Registrar		State o			Эера	ırtmen	t of H		and M			ne2 U	U6		8 8	
Decedent's Nam	ne (First, Middle	. Last)								2. Date of				3. Tim	e of Death	
		ald House	ho1de	er						Month	112	3/20	06	6: 2	5 PM	
ta. Facility Name	(If not institution,	give street and nu				4b. City,	Town, o	Location	of Death	'		4c. County	of Death			
ST.	AGNES	s Hust	ATI			,	1391	time	re	MP	•		n/a			
5. Social Security I 220-66-5		6. Sex 1 2 M 2 □ F	7. Age (Ir 50	n yrs. last bir	thday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month, 7/14	Birth Day, Ye /195	ear)	9. Birth Cou Mar	place (Stantry) y Lanc	te or Foreigi	7
Usual Residence	of Decedent															
10a. State	10b. County		10	c. City, Tow	n or Lo	cation									e City Limits	- 1
MD	Ba1t	imore		ARei	lay	5								1 🗆 ነ	res 2⊠No	'
10e. Street and Nu	umber					10f. Zip	Code				10g.	. Citizen of	What Cou	ntry?		
1103 F	rancis	Ave					1227					Unite				
11. Marital Status		12. Was Dec	rces?		13. V	Nas Deced	dent of H	ispanic Ori in, Mexicar	igin? (Sp	ecify Yes or Rican, etc.	No-			can Indiar etc.	١,	
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 No 1976— If Yes, Give Year or Dates: 1978 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American India Black, White, etc. 1 Yes 2 No Specify: Whi												Whit	е			
Elementary/Sec	condary (0-12) 12	College (1-4or 5+)	Na				" c Who	1esa	les		Wareh	ousi	ng		
17. Father's Name	(First, Middle,	Last)						18. Moth	er's Nam	e (First, Mic	idle, Ma	iden Sumar	пө)			
H. Donal	ld House	holder						Ma	rie	Canby						
19a. Informant's N				19b	. Mailin	a Address	(Street			al Route Nu	mber, C	ity or Town,	State, Zi	p Code)		
Karen Bi				11	03	Fran	cis.	Ave A	Rela	ys, M	ary1	and 2	1227			1
20a. Method of Di			:	20b. Place o	f Dispo	sition (Nar	ne of			Date		c. Location		own, State	—	
1 🔀 Buriai 2		3 □Removal from pecify)	State	Loudo		natory`or o ark C			5/22	2/2006	Ва	altimo	re,	Mary.	Land	
21. Signature of F	uneral Service	Licens e	Λ		22	. Name ar	d Addre	ss of Facili	ty Am	orose	Fune	eral E	Iome,	Inc		
))	an re	Stubby	JL			1328	Su1p	hur S	Sprin	ng Rd	Arbı	ıtus,	Mary	1and	21227	1
shock, or he	art failure. List	complications that only one cause on	each line.				le of dyir	g, such as	cardiac	or respirato	ry arrest	,		Approxi Interval Onset a	mate Between nd Death	
Immediate Cause disease or condit	ion	_ a	r	rwy	non	10								200	ays	
resulting in death)	Due to	(or as a co	onsequence V465	of): Hv	ہو ہ	Hee	ivt	fa	iluve	,			64	1 8975	
Sequentially list of any, leading to cause. Enter Und	onditions,	b. Oue to	(100000	onsectionne												
Cause (Disease of that initiated even	or injurý its	c		ebro		ascu	la	<u>a</u>	cc	iden	t			104	Pays	
resulting in death	, Last	d	(or as a co	insequence	ot): Hs	M	ell	itus						104	ears	
IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2 9 Unknow	2 months?		birth 2 [nant at tim	oregnancy □Fetal death le of death]Ectopic p] Other (sp							ate of delive	ery Day	Year	

Physician /Medical **Examiner**

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Be Completed

2

Certification:

Medical

Immediate Cause disease or conditi resulting in death) Sequentially list community, loaning to many, loaning to many, loaning to many, loaning to the cause (Disease of that initiated event resulting in death) Physician/Medical Examiner IF FEMALE:

Directo

Be Completed by Funeral

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Physician

/Medical

Examiner

Funeral

Director

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably Unknown

25. Was case referred to medical examiner?

Inpatient 2 ER/Outpatient 3 DOA

24a. Was an autopsy 26. Place of Death (Check only one) 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No

1 Yes 1 No 27. Manner of Death Natural 2 Accident

28a. Date of Injury (Month, Day Year) 5 Pending investigation

Hospital:

28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

29a. Certifier

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

TARIO MAHMOOD

May, 18, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

906 - Caton Ave Baltimor 906 - Caton 31. Date filed Mark Day 32006

State Registrar 32. Registrar's Signature

within 24 hours after death. To tha Funaral Diractor: After this certificate has

To the Hospital or Attending Physician:

		-	For State Registrar	State of Marylan		ment of I		d Mental Hy	giene Reg. No. 20	06 6 82					
	Physicia		1. Decedent's Name (First, Middle, Last	Holley				2. Date of De Month M CW	Day /	Year 05: 20 AM					
	/Medic Examin		4a. Facility Name (If not institution, give Hovend Coun	street and number) by Genhal	Hosp.	(or Location of D	beai		of Death					
	Funeral Director		330-14-0813	x 7. Age (In yrs. 81		f Under 1 Year Months Days		Hrs. 8. Date of Bir Min. (Month, Da OCT 30	th ay, Year) , 1924	9. Birthplace (State or Foreign Country) Illinois					
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Locat					10d. Inside City Limits 1 ☐ Yes 2 🕅 No					
	in the Ma or 28a-f	Funeral Director	Maryland Howard 10e. Street and Number			10f. Zip Code	cott Ci	ty	10g. Citizen of W						
	ath wi	le l	3261 Halcyon Cou				21043			JSA					
920	J within 72 hours after death with the Maryland jiene. Then "natural", or iteme 23e or 28e-f show the Madical Examiner must be mailfied at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		s Decedent of les, specify Cub		? (Specify Yes or No ruerto Rican, etc.)	Black	- American Indian, c, White, etc. White					
Maryland 21215-0036	within ine. Ihen	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give kin	NOT use retire	during most of	working	16b. Kind of Bus	siness/Industry					
d 2	II the	မ င်	17. Father's Name (First, Middle, Last)		Cielk		18. Mother's	Name (First, Middle		·					
ylan	0 0 0 0	To B	Michael Bariac		10h Mailin	Address /Ctros		oinette or Rural Route Numb	or City or Tourn	UNK.					
	od 2:		Jade D. Frey/Daug					Ellicot							
nore	M O		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	Place of Dispositi cemetery, cremate tro Cren	ory or other pla	1	Date /23/06	20c. Location - C	Co MD					
Baltimore,	permit. Page Department (important: If eny injury or		21. Signature of Funeral Seprice Licens Edward A. Gre	900	Cremation ad Balti	Society	of MD, Inc.								
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	stroke	Approximate Interval Between Onset and Death										
	/Medical Examiner		resulting in death)												
V	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ated events c.											
8760, <	be executed sicien and burial-transit	ical Exa	resulting in death) Last	initiated events											
9	tificate og physi as the			<u> </u>											
.O. Box	The law requires that the death certificate be executed ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	aldeath 3 ⊟Ed	ctopic pregnand ther (specify) _	су		23d. Date Mon	e of delivery th Day Year					
٥.	w requires that t been signed by should be deta	5	Part II. Other significant conditions co	ontributing to death but not re	sulting in the unde	erlying cause g	iven in Part I.			bute to the cause of death? 3 Probably 4 Unknown					
Records,	The taw re ate hes bee page 2 sho	Completed		Vere autopsy findings available rior to completion of cause of eath? Yes 2 No											
Vital	ician: Th certificate ector. pag	Bec	25. Was case referred to medical examiner?				26. Place of	1 ☐ Yes Death (Check only)	2 No 11						
of V	Physicil this cer al direct	2	1 ☐ Yes 2 No		ER/Outpatient	3LI DOA		ng Home 5 ☐ Res							
	ding After funer	ıtlon:	27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1	ıryat ork?]Yes 2.∏No		how injury occurre	90					
Division	if or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci		t, factory, office)		(Street and Numbe wn, State)	or or Rural Route Number,					
-	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in b	Medical C													
	To the Mithin To the	Me	29b. Signature and title of certifier			29c. Licer	ise number	_	29d. Date signed	(Month, Day, Year)					
	1		1/2 (n	Mo		DS	5087	U	may 2	2 nd 2006					
_	6		30. Name and address of person who s	completed cause of death (Ite	m 23a) (Type, Pri	ini) Bel	l la	ne cl	arksii	lle MD 21029					
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 2 3 20	32 Registrar's Sign	ature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Lynn Henry Darlene 2006 11:45 A^M 17, May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Towson Baltimore County Gilchrist Home for Hospice Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5 Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 ☐ M 2 🔯 F 213-88-3942 Yrs. 38 12-11-1967 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 28a-f show s 23a or 28a-f shov Lutherville 1 ☐ Yes 2XXIIIO Completed by Funeral Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21093 34 Othoridge Road 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married 5-0036 ō 1 ☐ Yes XX No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) St. Thomas Aquinas Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Catholic School School Teacher 6 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental I Janet L. Howard L. Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is meny injury or other treum once. 34 Othoridge Road Lutherville, MD 21093 Howard L. Henry Father 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a, Method of Disposition *Burial 2 Cremation 3 Removal from State 5/20/2006 Fullerton, Maryland Gardens of Faith 1 4 ☐ Donation 5 ☐ Other (Specify) Burgee-Henss-Seitz Funeral Home, Inc. Burgee-Henss-Seitz Funeral Home, Inc. 21211 21. Signature Juneral Service Licensee Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Du to (or s a consequence of): Years disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): 68760 certificate be Physiclan/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) 4☐Pregnant at time of death P.O. he 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 21**2** No 1 ☐ Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ihis 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After Division 1X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 📂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 58303 MM 17 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. CHARLES STREET

DHMH 17 Rev 1/2001

Registrar

4

32. Registrar's Signature

The said

IOWSON MD

21204

AMON J. CHALLES, MM

2006

31. Date filed (Month, Day, Year)

	1 - For State Registra 1. Decedent's	r Name (First, Middle,	Last)		Ce	rtificat	te of l	Death	2. Date of D	Reg. No.	<u> </u>	3. Time of Death
ysician Medical		, , , , , , , , , , , , , , , , , , , ,		Eldridg	e Holm	es			Month	May 19,	2006 Year	3:15 a.m.
aminer	4a. Facility Na	me (If not institution,				4b. City,	, Town, or	Location of Deat	h Fowson	4c. (County of Death Ba	Itimore
ral	5. Social Secu	rity Number 6	Stella l		s. last birthday)		r 1 Year	If Under 24 Hrs	8. Date of Bi	rth		place (State or Foreig
		48-6374	1 X M 2□F		69 Yrs.	Months	Days	Hours Min.	(Month, D			ntry) Florida
ı	Usual Reside 10a. State	10b. County		10c. (City, Town or Lo	cation			•			10d. Inside City Limit
ţŏ	Marylan	d	Howard				(Columbia				1 ☐ Yes 2 🗷 N
Funeral Director	10e. Street ar					10f. Zij	p Code			10g. Citiz	en of What Cou	
gra		Eaglebeak Ro		cedent Ever in	11.6	Was Dass	don't of 1 to	21045	Specific Ven or N	. 1	4. Race - Ameri	S.A.
þ		atus Married 20 Marrie wed 4 □ Divorced	Armed F	orces? 2 □ No ive		If Yes, spe	.)	ispanic Origin? (S in, Mexican, Puer Specify:	to Rican, etc.)		Black, White	
Completed		15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usu kind of wa	al Occupa	ation during most of wo	rking	16b. Kin	d of Business/I	,
dm	Elementary	/Secondary (0-12)	College ((1-4or 5+)	life.	DO NOT u		Lt. Colonel			U.S.	Army
Be Co	17. Father's N	ame (First, Middle, La		<u>-</u>			1101.	18. Mother's Nai	me (First, Middle	, Maiden S	Sumame)	
To B		Cha	rles Holme	s					R	osa Lee	Poole	
ľ	19a. Informa	nt's Name/Relationshi	p (Type, Print)			-		and Number or Ru				Code)
Ш	Mrs.	Jean W. Holn	nes	Wife	. Place of Dispo			eak Row Col	umbia, Mar		1045 ation - City or T	own State
	1) Buria	I 2 ☐ Cremation 3		I	cemetery, crei	natory or o	other plac	n	5/24/2006	20c. Loc		e, Maryland
		tion 5 ☐ Other (Spe of Funeral Service Li				bia Me . Name a		Park:	0/24/2000		Olarksville	, wai yiai u
	nk.	mlulla	Shel	MOO	سے دی		Slack I	Funeral Hon Old Columbia	ne P.A.	att City	MD 21042	
ai Examiner	Sequentially if any, loading cause. Enter Cause (Disea that initiated resulting in di	ist conditions, to immediate Underlying se or injury wents eath) Last	c	(or as a conse								
			d									
by Physician/Media	in the pa	eedent pregnant ist 12 months? 2 \square No nown	1 ☐ Live	utcome of preg birth 2 Fe mant at time of nown	ital death 3	Ectopic p Other (s				23	3d. Date of deliv Month	ery Day Year
d by Pi	Part II. Other	significant condition	s contributing to o	death but not re	esulting in the u	nderlying o	cause give	en in Part I.				he cause of death?
Completed									24a. Was	an	24b. Were auto	opsy findings availab
E O									auto perfe 1 ☐ Yes	ormed?	prior to co death?	mpletion of cause of 2□ No
BeC	25. Was case examiner	referred to medical					11000	26. Place of Dea	ath Check only	-		2010
2	1 ☐ Yes	2X No			ER/Outpatier			# Li Nui Sing F				HOSPICE
catlon	27. Manner of	al 5 ☐ Pending lent investiga	tion	of Injury oth, Day Year)	28b. Time of Injury	м	28c. Injury Work	y at (? Yes 2 □ No	28d. Describe	how injury	occurred	
=		datamin	ed 286. Plac			eet, factor	y, office		28f. Location (City or To	Street and wn, State)	Number or Run	al Route Number,
The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s								ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) a	and manner as solace, and due t	tated. o the cause(s)
edical Certi	29a. Certifier (Check one)	1X Certifying 1by 2 ☐ Medical E	xeminer: On the t and mar	basis of exami nner stated.	nation and or in	roonganor						
Medical Certification:	(Check o	Certifying Certifying Medical E and title of certifier	xeminer: On the t and mar	basis of exami nner stated.			c. License				signed (Month,	Day, Year)

DHMH 17 Rev 1/2001

MAY 19, 2006 3:15 a.m.

ALLEN HOLMES

			For State Registrar		State	of Marylan	•	artmen			and M		giene	Z U II I	5	16185	5
	Dhusisi		1. Decedent's Name (F	irst, Middle,	Last)							2. Date of De	aath Day	y Yea	r	3. Time of Death	
	Physici /Medio Examir	cal	Theodore 4a. Facility Name (If no			fman, Sr	•	4b. City,	Town, or	Location o	of Death	May 16	, 20			12:30 P ^M	1
			4740 Wate	er Par	k Drive	Unit C		Belc					Н	arford			
	Funeral Director		5. Social Security Number 093-12-8209		Sex Maria 2☐ F	7. Age (In yrs. 85	last birthday) Yrs.	If Under Months		If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Jan. 1	ay, Year)			ce (State or Foreigr y) sylvania	n
	<u>p</u> ,		Usual Residence of De	ecedent													_
	anylar show	<u>.</u>	10a. State 10	0b. County		10c. Cit	y, Town or Lo	cation							100	1. Inside City Limits	
	88-f	cto		Harfor	d	Belo	camp									1 ☐ Yes 2√∑No	
	vith th	by Funeral Director	10e. Street and Numbe	ər				10f. Zip				İ	10g. Cit	izen of What (Country	y?	
	ath v	a	4740 Wate	er Par			- [210					USA	14.5			
	er de	nne	11. Marital Status		Armed f	cedent Ever in U. Forces?	.S. 13.	Was Deced If Yes, spec	lent of Hi offy Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto	cify Yes or No Rican, etc.))-	14. Race - An Black, Wh			
36	s aft	y F	1 Never Married 3 Widowed 4	2.	d 1 Lyyes If Yes, C Year or	2 □ No Bive		1 ☐ Yes 2	2 N 0	Specify:				Specify:		• •	
5-0036	72 hours after death with the Maryland natural', or Items 23a or 28e-f show dical Examinar must be notified at			i. Decedent's		Dates.	16a. Dece	dent's Usua	I Occupa	ation			16b. K	ind of Busines		<u>ite</u>	
215	in 72 n "ns	piet	(Specify (only highest	grade completed	·	(Give	kind of wor DO NOT us	rk done a	during most	t of worki	ng				v., y	
212	filed within Hygiene. other than " ent, the Mas	Completed	Elementary/Seconda	ary (0-12)	College	(1-4or 5+)	Sale	sman					Fre	ight C	omro:	anv	
	e filled I Hyg othe /ent,	Be C	17. Father's Name (Fire	st, Middle, La	ast)					18. Mothe	r's Name	(First, Middle			onip.	<u>-</u>	_
<u>a</u>	uld be fental rked c	To B	Joseph (ı	unk) H	offman					Eliz	abet	h (un	k) E	lias			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 ie marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name				19b. Maili	ng Address	(Street a			l Route Numb			, Zip C	ode)	
	alth alth a	:	Martha E.	Hoffm	an / Wii	fe	4740	Wate	r Pa	rk Dr	rive,	Unit	С, В	elcamp	, M	D 21017	
Baltimore,	ss 1 and the street of Heart of the		20a. Method of Disposi			20b. P	lace of Dispo emetery, crea	sition (Nan	ne of ther place	e)	C	ate	20c. Lc	cation - City	or Tow	n, State	
Ē	Page nent c nt: If		1 ☐ Burial 2 🛣0 `4 ☐ Donation 5 [II State	lltop			1	5-18	-06	TOTAL	son, M	2 1 777	land	
alti	permit. Departm Importe any Inju		21. Signature of Funer	al/Service Li	censee	/						me, P.	7	SOII, I'I	ary.	Lana	
m	Depa Impo any Ir		stesi	3//	Buch	1		1317	as r Coke	sbury	r Roa	me, P. d. Abi	nado A•	n Mars	ທີ່ລາ	nd 21009	
			23a. Part1. Enter the o	disease, or o	omplications that	caused the death								114-1-111-	A	pproximate nterval Between	
	Physician		Immediate Cause (Fin		ny one-cause of	COD									Ö	Inset and Death	
4	/Medical		disease or condition resulting in death)	19	aDue to	o (or as a conseq	uence_of):						-			17903	
	Examiner			. 1		una		nce	N						4	1/0/	
		Jer	Sequentially list condit if any, leading to imme cause. Enter Underlyin Cause (Disease or inju-	tions, edi <i>a</i> te	Due to	(or as a conse	uence of):	2 1							,	1/2/	
1	cuted	Examiner	that initiated events		C	Jesp.	· F	ail	w	e					1 5	1/06	
0	exer an ar irial-t	Exi	resulting in death) Last	t	Due to	o (or as a consequ	uence of):										
8760,	death certificate be executed e attending physician and of for use as the burial-transit	ical		,	d										-		_
9	ntifica ng ph	Physician/Med	IF FEMALE:				-										-
Box	ath ce ttendi	an/	23b. Was decedent pro in the past 12 mo		1 Live	utcome of pregna birth 2 - Feta	death 3[Ectopic pr					1	23d. Date of d Month	-	ay Year	
	e dea the at	sici	1 Yes 2 No		4□ Pre	gnant at time of de mown	eath 5	Other (sp.	ecify)	··				MONTH		ay rear	
P.0	d by letach	Phy	Part II. Other significal	nt condition	C contribution to	dooth but not son	ulting in the w	ndoshin- o		in Oned I		220 Did	abassa u	an nentributo	to the	cause of death?	_
Records,	law requires that the death certifics as been signed by the attending ph 2 should be detached for use as t	ed by	Part II. Other significa	nt condition	s contributing to	death but not rest	ulling in the u	nderlying ca	ause give	in in Part I.			Yes 2		Probab	-	ı
00	s bee	Completed										24a. Was		24b. Were	autops	y findings available)
Re	The lav	mo	-										rmed?	death?	?	letion of cause of ☐ No	
Vital	en: Tiffica tor, p	(a)	25. Was case referred	to medical						26. Place	of Death	(Check only of	2 No	1010	3 21		_
>	Physicien: this certific ral director,	lo B	examiner? 1 ☐ Yes 2 ₹No		Hospital:	Inpatient 2	ER/Outpatier	nt 3 DO	A Othe	251		ne 5 Resi		3 ☐ Other (Sp	ecify)		
J Of	ig Ph ter th neral	n; T	27. Manner of Death		28a. Dat	e of Injury onth, Day Year)	28b. Time o	2	8c. Injury Work	at	2	28d. Describe	how injur	y occurred			_
io	Attending r death. ector: After by the funer	atic	2 Accident	5 Pending investiga	tion	,,	,,	М		res 2□N	Vo						
Division	r Atte er de recto by th	tific	3 ☐ Suicide 6 4 ☐ Homicide	Could no determin	ed 286. Plac	ce of Injury - At ho	ome, farm, str	eet, factory	, office		2	28f. Location (d Number or I	Rural F	Route Number,	
	rs efte rs efte al Dir	Certification:				3, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,											
	To the Hospitel or Attending Phyelcien: The I within 24 hours effer death. To the Funeral Director: Affer this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 (Check only 2 one)	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
	To the within 2 To the complet	Σ	29b. Signature and title	e of certifier	m-An	^ (D	29c	License	number	7-	7 7	29d. Dat	e signed (Mor	oth, Da	y, Year)	
) / W	MIL		0 111				NY.	16	11		5/19	10	6	
	AXI		30. Name and address	um	120	use of death (Item	1 23a) (Type,	Print) /	0	Ur	丁(1): ノ	mc	900	21019	1	FSMO	
	Sta Registi		31. Date filed (Month)	Date filed (Month, Day, Year) WAY 2 3 2006 32 Segistrar's Signature													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 26 per doc 9855 5-23-06 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death I. Decedent's Name (First, Middle, Last) May 9, 2006 10:15P M Mamie B. Harris 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Prince Georges 13551 Belle Chase Blvd Unit 413 Laurel If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 🖾 F Vrs Sept 8, NC 97 239-58-3260 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 ☐ No New Hanover Wilmington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28401 USA 1020 S. 8th St 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√ No Specify: 3√XVidowed 4 □ Divorced **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public School System 12 Educator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Noyes Jacob Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13551 Belle Chase Blvd Unit 413 Laurel, MD 20707 Harold Harris Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Greenlawn Memorial Pk 1 Burial 2 Cremation 3 Removal from State 5-16-06 Wilmington, NC 28401 ° 4 ☐ Donation 5 Other (Specify) r (of Energy Source bicon) Fink Funeral Home, P.A. 426 Crain Hwy Sw, Glen Burnie, MD 21. Signatur K. 21061 Kink MO1148 Gregory ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscleratio Heart Years disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ens10.7 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) son s Hospital: Other: 4 Nursing Home ** Nursing Home ** Nursing Home ** Nursing Home ** Other (Specify residence 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1XNatural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

7500 Greenwel

D37934

Examiner The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760 attending physician use as the for the detached has page 2 To the Hospital or Attanding Physician: filled in by the funeral director, this After t s after death. 24 hours within 24 ho To tha Funs completely f

Physician

/Medical

Examiner

Director

ģ

Funeral

Director

27 is marked othar than "natural", or Items 23a or 28a-f show traumatic evant, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Items 23s any injury or other traumatic event, the Medical Exampler must. once.

Physician

/Medical

Physician/Medical Examiner

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Completed

Be

P

Certification:

Medical

29a. Certifier

Baltimore, Maryland 21215-0036

with the Maryland

DHMH 17 Rev 1/2001

State Registrar

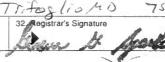
31. Date filed (Month, Day, Year) 2006

-ephanic

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

5+



ORIGINAL

Center Drive Green Selt AD 20170

29d. Date signed (Month, Day, Year)

05/10/2006

	1	For State Registrar		Marylan		artmen rtificate			ına M		Reg. No	711	06	16	187
nysician		. Decedent's Name (First, Middle, Maria Isabel Jon	-						1	2. Date of De Month May	ath 20	y 2	2008		of Death A • M
Medical xaminer		a. Facility Name (If not institution, g Stella Maris	ive street and nun	nber)		45. City, T1M	Town, or ONIU	Location o	of Death		B B	.County alti	of Death MOre	Coun	ty
eral ector		212-54-9301	Sex XX 1□M 2□F	7. Age (In yrs. 75	last birthday) Yrs.	If Under Months	1 Year Days	If Under	Min.	8. Date of Bi	rth 3y, Year, 5, 19	30	9. Birthi Chépe	place (Stat 200) P	e o <i>r Foreig</i> n eru
tor		Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo	ore Count		ry, Town or Lo										City Limits
any injury or other traumatic event, the Madical Examinar must be notified at once. To Be Completed by Funeral Director		10e. Street and Number 13 Kilmory Cour	=			10f. Zip 212					-		What Cou State		
by Funeral Director	200	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed For	2 ⊡ No e		Was Deced If Yes, spec		spanic Ori n, Mexican Specify	gin? (Spe , Puerto f Outh	city Yes or No Rican, etc.) Americ	can	Bla	ck, White,	can Indian etc. panic	
Completed	Basadina	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (1 N/A	-4or 5+)	16a Dece (Give Libra	dent's Usua kind of wo DO NOT us LY Re	al Occupa rk done d se retired fere:	ation during most) nce T	of workin	ng ician	J.	H.U.	Milt Libra	ton E	isen-
To Be C	3	17. Father's Name (First, Middle, La Thelmo Razuri	st)							(First, Middle nzales	, Maidei	Sumar	me)		
		19a. Informant's Name/Relationship Mr. D. Daniel Jo		sband)						<i>i Route Numb</i> y Hall					
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State EV	Place of Disponentery, creams Fu	nsition (Nar. matory oco neral	ne of other plac Chaj	pel M	ay 2	ate 2, 200	20c. L	ocation Ores	- City or To	own, State	arylan
once.		21. Signature of Funeral Service Line 23a. Part1. Enter the disease, or conshock, or heart failure. List or	Lesur	~	P ₂	2. Name an eacefi 325 Yo	ad Addres ul A ork	is of Facilit Itern Road,	ativ Tim	es Fund Onium M	eral Mary	&Cre	matic 1, 210	on Ct 193	r.P.A.
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Physician/Med	yalolola	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown		irth 2 ☐ Feta ant at time of c	aldeath 3[⊒Ectopic pr ⊒ Other (sp							ate of deliv	ery Day	Year
3 2	2	Part II. Other significant condition	s contributing to de	eath but not res	sulting in the t	inderlying c	ause give	en in Part I			tobacco Yes 2	_		he cause o	of death?
om C										24a. Was auto perf 1 □ Yes	opsy ormed?		Were auto prior to co death? 1 \(\sum \text{Yes}	impletion o	gs available it cause of
Gertification: To Be 6	2	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no	28a. Date (Mont	of Injury th, Day Year)	ER/Outpatie 28b. Time o Injury	of 2	28c. Injun Worl	er: 4 □ Nu	nrsing Hor	Check only ne 5 ☐ Res 28d. Describe	idence how inju	iry occur	rred		
completely filled in by the funeral		4 Homicide determin	209. Flace	of Injury - At h ng, etc. <i>(Speci</i>	(y)			un objete see		28f. Location City or To	wn, Stat	e)			umber,
mpletely fil	- מחוכם	(Check only 2 Medical E.	caminer: On the ba			vestigation	, in my o	pinion, dea			, date an	d place,	and due t	o the caus	` '
COU	•	29b. Signature and title of certifier)1			290	DA		25				ed (Month,	1	7)
completely filled in by the		29b. Signature and title of certifier 30. Name and address of person w DR. TARIO MAHMO 31. Date filed (Month, Day, Year)	no completed caus	e of death (Ite	Y VALI	, Print)	D4	onumber	25 IUM,	MD 210			,	Day, Year	-)

MAY 20, 2006 6:40 a.m.

MARIA JONES

		State of Maryland / Department of Health and N 1- State Registrer Certificate of Death		ene 006	16188
Physic	ian	1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year	3. Time of Death
/Medi		Julie T. Jenkins	May	4c. County of Death	2.25P M
Exami	ner	4a. Facility Name (If not institution, give street and pumber) 4b. City, Town, or Location of Death NOV/NM (1000-100) HOS D. + Al Politimore C +	1/	N/A	_
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Birth	place (State or Foreign
Director		214–50–0275 1 1 1 1 1 1 1 1 1	oct. 20,	1946 Mar	yland
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryla fed	lo	Maryland N/A Baltimore			Wes 2 □ No
r 28e	rec	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	untry?
th with	Funeral Director	2637 St. Paul Street Apt TA 21218		USA	
r dee	nuel	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
rs afte	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 No H Yes, Give 1 □ Yes 2 No Specify: 3 ☑ Widowed 4 □ Divorced Year or Dates:		Specify:	White
2 hou		15. Decedent's Education 16a. Decedent's Usual Occupation	11	6b. Kind of Business/l	ndustry
thin 7	Completed	(Specify only highest grade completed) (Give kind of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during	(IIIg	D1- D:	3.2
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should nd Me mark	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	ral Route Number,	City or Town, State, Z	ip Code)
and 2 ealth a m 27 ie		Brian Jenkins Son 928 220th Street, Pas	adena, Ma	aryland 2	1122
of He		cemetery, crematory or other place)		0c. Location - City or	
Pages tment of tant: If Ite		4 Donation 5 Other (Specify) St. Mary's Cemetery 5/25		Baltimore,	
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 ie marked other then "natural", or items 23a or 28e-f ehov and injury or other traumatic event, its Medical Event at must be notified at once.		21. Signature of Funeral Service Licensee 12. Name and Address of Facility Burgee-Henss-Seitz 3631 Falls Road, B	Funeral altimore,	Home, Inc Maryland	. 21211
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
Physician	н	Immediate Cause (Final disease or condition a. MC+aStatic In/roid Cance resulting in death)	2		Onset and Death
/Medical Examiner		Due to (or as a consequence of):			
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her the death certificate be executed ed by the ettending physicien and detached for use as the burial-transit	dicai	d			
certifii ding I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of deli	verv
death death death	iciar	in the past 12 months? 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map 1 Very 2 Map		Month	Day Year
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n & 2.3	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	the cause of death?
requir	eted				
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ysicie is cert direct	To B	examiner?		ce 6 □Other (Spec	ify)
ng Phy fter thii		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Injury Work?	28d. Describe how	v injury occurred	
Seath.	cati	2 Accident Investigation M 1 Yes 2 No	004 1		10
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To the Hospitel or Attending Physicien: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should	edical (29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the cau rred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
To the within To the compl	Me	29b. Signature till e of certifier 29c, License number	-FO 29	d. Date signed (Month	, Day, Year)
4		Kei Churchart 845	22 //	(ay 20,	2006
7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	anc/ /	loca to	/
~	tate	31. Date filed (Month, Day, Year) / 32. Registrar's Signature	14/7	rypual	
Regist		MAY 2 3 2006 Page & Sparker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 📋 For State Registre Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician ROSA ELLEN JAMES 18, 2006 11:00 A.M MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1757 WENTWORTH AVENUE BALTIMORE PARKVILLE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 □ **X**F Yrs. 219-30-1894 3/9/193 MARYLAND Director Usual Residence of Decedent 10a State 10c, City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other treumatic event, the Medical Exeminer must be nutified at 1 ☐ Yes 2 ☐XNo PARKVILLE MD BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 1757 WENTWORTH AVENUE USA 21234 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 2 WHITE 3 XWidowed 4 ☐ Divorced "nature!" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygienn Important: if item 27 is marked other the any injury or other treumatic event, Iha. 2008. JOHNS HOPKINS SECRETARY 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JAMES JACOBS ROSE HEIL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1757 WENTWORTH AVENUE BALTIMORE, MD 21234 MELISSA GARRETT/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/20/2006 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. CATONSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Fail. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. 8521 LOCH RAVEN BLVD. TOWSON, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 30 Minutes Myocardial Infarction /Medical Due to (or as a consequence of): Examiner 20 YEARS Atherosclerosis vascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner he attending physician and it for use as the burial-transit death certificate be executed Diabetes 20 YEARS that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ል page 2 should be 1 Yes 3 ☐ Probably 4 ☐ Unknown Hypertension, Hyperlipidemia Completed certificate has been 24b: Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after death unerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide To the Hospital within 24 hours a To the Funerel I completely filled 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifie

10. Name and ordress of person who completed cause of death (Item 23a) (Type, Print)

ROGER S. BLUMENTHAL, MD 600 N. WOLFE STREET 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

29c. License number

0034516

BALTIMORE, MD

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

3 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 19, **Physician** Don Carroll Keplinger 12:45 PM Mau 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town, or Location of Death Examiner Baltimore 5313 Bush Street White Marsh 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
April 7, 1940 Tennessee If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**∑**M 2□F Months Days Hours 66 Yrs. 217-38-8087 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a State 10h Counts item 27 is marked other than "naturel", or items 23e or 28a-f show other treumatic event. The Nextical Exprisement for notified at 1 ☐ Yes 2 WNo Director Maryland Baltimore White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5313 Bush Street 21162 U.S.A. by Funeral death 1 permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other treumatic even. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Installer Cable Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Keplinger Evelyn Sue Carson Kyle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5313 Bush Street, White Marsh, MD 21162 Lelon Sutherland (step-father) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Mem'l Gar. 5/22/2006 Baltimore, Maryland `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cerebero Vascular Accident Immediate Cause (Final Lecurent **Physician** disease or condition resulting in death) /Medical CardioVascular Disease Altero sclenotic Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year ğ Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown ģ tor; After this certificate has been signed I the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 1 Yes 2 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 1 Yes 2 No 5 Residence 6 □Other (Specify) 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ramish Sahapalm 201-109 Rack Rivid Nock Read Balthma 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar

		•	For State Registrar	State of Ma	aryland / De	epartmen Certificate			and M		giene Reg. No.	6	5	32
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3	Funeral Director				75 Yrs	Months	Days	Hours	Min.	Jan. 2	9, Year) 9, 1931	Cou	NJ	
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36	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-f show tha M. ciral Exeminet must be notilised at	by Fu	1 Never Married 2 Married	1 X Yes 2 ☐ N If Yes, Give	No	1 🗆 Yes		Specify:		,	Specify:		nite	
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ē,	f Hea f Hea item		20a. Method of Disposition		20b. Place of D		ne of			ate	20c. Location - (
E	Page nent o int: if iry or		1 ☐ Burial 2 🛣 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	A11 Cou				5/20/	'06	Sykesvi	11e,	MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if Item 27 is marked other than "natural", or Items 23a or 28e-f show eny injury or other traumatic event, the M-dical Exeminer must be notified at Once.		21. Signature of Funeral Service Licensee	wight		HAIGHT Sykes	Address FUN	ERAL e. MI	у НОМЕ О 217	E & CHAI	PEL,PA (1	Box 1400	195)	
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	7		30. Name and address of person who con		eath (Item 23a) (Ty SU(76 ICR	pe, Print)	112	OPT	RA	Elders	hus an	21	784	
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	Regist	rar	MAY 2 3 200	6 1	20 M.	Specker								

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Physician/ Medical Examine	7	David M.	Kerby				-	2. Date of De Month May 17, 2	ath	3. Time of Death
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Funeral Director			XM 2 F	e (in yrs, ia	ast birthday) 2 Yrs.	If Under 1 Months	Days Hours	Min.		reign Country) Maryland
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Re Commissed by	ב ב	Stephen W. K					Debo	rah A. M	acciola	
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Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service Lic		11	22. N	ame and Add	ress of Facility	300 Mac	e Ave. Ba	altimore MD
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Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 9. Birthplace (State or Foreign 1 ☐ M 2 1 F **Funeral** Maryland 12-03-2073 Yrs. Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f ehow r than "naturel", or iteme 23a or 28e-f ehover the Medical Examiner must be notified at Md Baltimore Baltimore **Funeral Director** 1√2 Yes 2 No 10e, Street and Number 10f Zin Code 10g. Citizen of What Country? 648 South Curley Street 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🖔 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify: White Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) Homemaker own home permit. Pages 1 and 2 should be filed v
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Important: if Item 27 ie marked other th
any injury or other treumatic event, tha
once. 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Roland Cole Dora Burkamski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet King /daughter 49 Coolbreeze Drive Balto. MD 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State M Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 5/24/06 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the deether shock, or heart failure. List only one cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
UNandi compo Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Que to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The taw requires that the death certificate be executed **burlal-transit** Due to (or as a consequence of): Box 68760, Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? we 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA andh.

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funeral dir 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 ☐ Accident within 24 hours efter death To the Funerel Director: , completaly filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 = Certifying Physician: To the best of my knowledge death ancurred at the lime, date and plane, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D-38754 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 709. BASTERN BLVD - MD - 21221 WASEEM. MALIKA 31. Date filed (Month, Day, Year) 32 Registrar's Signature MAY 2 3 2006 Registrar

			For State	State of Ma	aryland		artment of H			1	nns	1 5	195
			Registrar 1. Decedent's Name (First, Middle, Las	el .		Cer	lilicate of L	Jeani	2 Date of Dea	leg. No	. 6/ 6/ 6/	3 Time	of Death
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	pg		Usual Residence of Decedent		40- 07-	Ŧ						404 1	oh Harb
	arylar ehow	_	10a. State 10b. County		_	Town or Lo						10d. Inside	es 25 No
	88a-f	Director	Maryland Montgome	ry	Geri	mantov					n of What Co		42
	with ti		10e. Street and Number	No. 4-10	2		10f. Zip Code					,	
	filed within 72 hours after death with the Maryland Hygiene. other then "neturel", or iteme 23s or 28s-f ehow ent, the Madical Examiner must be motified at	Funerai	12809 Pinnacle I	12. Was Decedent 8		13 \	20874 Was Decedent of Hi	spanic Origin? (S			Race - Ame		
	iter d	E	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 21 N			f Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)		Black, White	e, etc.	
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Ŏ	2 ho	Completed	15. Decedent's Ed				dent's Usual Occupa		rking	16b. Kind	of Business/	Industry	
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7	ed wi	9	12			Acco	ountant				al Gov	rernme	nt
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$\frac{3}{5}$	ould Men Marke Marke	ဌ			Rece					elson			
Maryland 21215-0036	d 2 st th and 7 is n treun		19a. Informant's Name/Relationship (7) Joseph Koontz/Hust	• • • • • • • • • • • • • • • • • • • •			ng Address (Street a Pinnacle			-			7/1
Ġ.	1 and Heali		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name of		Date 24,		tion - City or		774
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "neturel; or items 23s or 28s-f ehow each injury or other treumatic event, the Marical Examiner must be multiled at Angles.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			-	natory`or other plac Ieaven	e) May 200		ilver	Spri	no. MD	1
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m	Der im p	> >	Som P Cha	cleu M(00092	Ro Ro	Name and Address ockville, ockville,	Inc. 30 Marylan	0 West M d 20850-	ontgo 2805	mery A	venue	nome
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П	e dea he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown			Other (specify)				Month	Day	Year
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>	Physician: r this certific ral director.	To B	examiner? 1 ☐ Yes 2% No	Hospital: 1 ☐ Inpatie	nt 2DE	R/Outpatien	nt 3 DOA Othe		tome 5 ☐ Resid		Other (Spe	ow Hos	nice
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Ö	Attending ir death. ector: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		7 7 0007	пцоту		Yes 2 □No					
Division of Vital Record	or Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubuilding, etc	ury - At hom c. (Specify)	ne, farm, str	eet, factory, office		28f. Location (S City or Tow		lumber or Ru	iral Route Nu	ımber,
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	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	Me	29b. Signature and title of certifier				29c. License		;	29d. Date s	igned (Montl	h, Day, Year)	+
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1	D		30. Name and address of persor who						\$				
	4		Joseph Kaplan,					l, Rockvi	llle, Mar	yland	2085.	5	
	Sta Registi		31. Date filed (Month, Day, Year) MAY 2 2 2	32. Sgistra	ai s Signatu	The Age	rester						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** OF: 48PM Mar Rosemarie Lecy 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Agnes Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Say 8. Date of Birth (Month, Day, Year) Dec. 25, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F 126-34-0109 1943 Puerto Rico 62 Director Usuel Residence of Decedent 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow valical Examiner must be notified at 1XYes 2 No Funeral Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 7215 Main Falls Circle 21228 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 end 2 should be filed within 72 hours after ment of Health and Mental Hygiene. and if item 27 ie marked other then "natural", or the ury or other traumatic event, the Moulcal Ear sing ury or other traumatic event, the Moulcal Ear sing 1 ☐ Never Married 2 Married Puerto Rican Baltimore, Maryland 21215-0036 1. Yes 2□ No À 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Analyst Social Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jose Barrios Esther Velez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clinton A. Lecy - Husband 7215 Main Falls Circle Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Pages
Department of
Important: If it
eny Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory May 23, 06 Baltimore, MD 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Raltimore, MD 21 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulling in death) Pnysician Hemorr hage ntracranial one week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initialed events resulting in death) Last Due to (or as a consequence of). Examine Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, nding physicien Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2/2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Rosemarie 1□Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Moenas May 17, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 5 Catons Avenue, Baltimore, Ragar Meena. 32 Registrar's Signature 31. Dale filed (Month, Day, Year) MAY 2 3 State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death I. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 1:00 P Sara Ellen Long May 21 2006 /Medical 4h. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Catonsville Baltimore 231 East Medwick Garth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XF 70 1935 Director 173-28-6692 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County other than "natural", or itsms 23e or 28e-f show 1 Tyes 2 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 231 East Medwick Garth USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Tax Assessor New York State permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked othr any injury or other traumatic avant, gonce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Long Hazel Duss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Cortes/Daughter 231 East Medwick Garth Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 5/23/06 Baltimore, MD 21. Signature Duneral Service Licensee

Edward A.) Gregorchik 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) nee Physician /Medical a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ensur physician and s the burial-transit Division of Vital Records. P.O. Box 68760. Physician/Medical as attending p for use as IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably as been signal 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? res 2 12 No page 212 No certificate 1 ☐ Yes 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After t 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident **Dirsctor**: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State 3 2006 Registrar

VOID

CERTIFICATE

2006-16198

SEE

CERTIFICATE #

2006-18869

Dreased- Timothy Russell Lane, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year R. **Physician** EV :35A MA 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** zenera toward er 1 Year | If Under 24 Hrs. JUN TO Towaro If Under 1 Year Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 20 F 70 Yrs. 218-72-7564 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at 90gs. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Dixes 2 No Funeral Directo towar 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6334 USA P016 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 NHO If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Drivorced Jhit Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic 19 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be evinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter 26 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Grematory 5 -06 5 Qther (Specify) 4 Donation 21. Signature of Funeral Service Licensee 22. Name and Address of acility WINDIM GEET Approximate Interval Between Onset and Death Iter the disease, or complications that or heart failure. List only one cause on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician how disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, fram leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto (or as a consequence of) been signed by the attending physicien and should be detached for use as the burial-transit To the Hospital or Attending Physicien: The law requires thet the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 ⊠Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? this certificate 1 Yes 2 🕱 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 2 X ER/Outpatient 3 ☐ DOA မ 1 Inpatient within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 82

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

		,	For State of Maryl	and / Department of Certificate of			ne _{No.} 2006	16201
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Frances LaRicci			2. Date of Death MAM9nth 18	B 2006	3. Time of Death 2:45AM
A Section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the sect	Examin		4a. Facility Name (If not institution, give street and number) 1303 Old Mountain Road		or Location of Death		4c. County of Deat Harford	
-	Funeral Director		232-66-5699 1□M 2⊠F	yrs. last birthday) If Under 1 Yea Months Day:	r If Under 24 Hrs. s Hours Min.	8. Date of Birth (Month Day, Y) DeC . 24	9. Birt Wes	hplace (State or Foreign ThirtyVirginia
	Maryland f ehow	or	,	. City, Town or Location Joppa				10d. Inside City Limits 1 ☐ Yes ※XXNo
	a or 28e-	Funeral Director	10e. Street and Number 1303 Old Mountain Road	South 10f. Zip Code 21	085	-	Citizen of What Co	Duntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28e-f ehow any injury or other treumatic event, the Medical Exerting Final Le Inditial at ance.	þ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2√□ No If Yes, Give Year or Dates:	in U.S. 13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp. ban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
21215-0036	s within 72 ho liene. r then "naturi the Wadical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use retir Deli Cle	e during most of work red)	ina	afeway	Industry
and	id be filed ental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle, Last) John G. Workman			e (First, Middle, Mai Melvin	den Sumame)	
Maryland	nd 2 shou Ith and M 27 Is mar r treumat	-	19a. Informant's Name/Relationship (Type, Print) Thomas C. LaRicci /son	19b. Mailing Address (Street				
Baltimore,	Pages 1 ar		20a Method of Disposition 20	Db. Place of Disposition (Name of opinion of the property), crematory or other property.	1	Date 200	altimore	Town, State
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Add	ress of Facility 300 11y Funer) Mace A	ve. Bal	to. MD
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the cause of the factor of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause	Cancer - S	ying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	acuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.					
8760,	cate be executed physicien and the burial-transit	dicai Ex	resulting in death) Last Due to (or as a condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of th	sequence of):				
P.O. Box 68	e death certifi the attending I ned for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2√2 No 9 ☐ Unknown 23c. If yes, outcome of production in the past 12 months? 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 Ectopic pregnan			23d. Date of del Month	ivery Day Year
	quires that the signed by all be detacled		Part II. Other significant conditions contributing to death but not	resulting in the underlying cause of	given in Part I.	23e. Did tobac	_	the cause of death?
Division of Vital Records,	The law requir rate has been si page 2 should	Completed				24a. Was an autopsy performed	1? death?	utopsy findings available completion of cause of
Vita	sicien: certific rector,	Be	25. Was case referred to medical examiner? Hospital:		\al	h (Check only one)		
٥	g Physier this	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of 28c. In:	4 Nursing Ho	me 5 Residence 28d. Describe how i		city)
ivisior	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation	M 1[At home, farm, street, factory, office	☐Yes 2☐No	28f. Location (Stree City or Town, S		ıral Route Number,
Ω	To the Hospital or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical Ce	29a. Certifier (Check only one) 29a Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examoner stated.	knowledge, death occurred at the nination and/or investigation, in my	time, date and place,	and due to the caus	e(s) and manner as and place, and due	stated. to the cause(s)
	To the I	Mec	one) and manner stated. 29b. Signature and title of certifier	29c. Lice	nse number	29d.	Date signed (Monti	h, Day, Year)
)	ın		30. Name and address of person who completed cause of death	(Item 23a) (Type, Print)	+6118	M	Ay 19	2006
	IU		JANET COOPER MD 10 31. Date (iled (Month, Day, Year) 32 Registrar's S	147 YORK R	d help	erville	MD 2	1093
	Sta Regist		MAY 2 3 2006	A parte				

		1 - For State Registrar					rtificat		ealth and i Death		Reg. No.	L 0 0 1) 1020	-
Physicia	ın		ne (First, Middle, Last							2. Date of D Month	eath Day		3. Time of Death	
/Medic	al		ony LaRi		harl		4h Cih	Tours	Location of Deat	05	- 19	5- 06	3:10PM	
Examine	er		(If not institution, give	. / .	. 1	60	46. City,		Ī /	n	-	County of Dea	10re	
Funeral		5. Social Security	Number 6. Se	/105pita	7. Age (In yrs.		If Under		If Under 24 Hrs.	8. Date of Bi			rthplace (State or Foreign	7
Director		218-22-	-6783 1 ¹⁰	X M 2□F	78	Yrs.	Months	Days	Hours Min.	8. Date of Bi (Month, D Jan3	, 1°92	8 MA	ryland	
p .		Usual Residence of	of Decedent 10b. County		10c Ci	ty, Town or Lo	cation						Taget tracide City Limite	_
aryla •hov	5	MD	Harfo	rd		Joppa	cation						10d. Inside City Limits 1 ☐ Yes 2 X No	
h the Maryland rr 28a-f ehow	rect	10e. Street and Nu					10f. Zig	Code			10a, Citi	izen of What C	ountry?	_
death with the Maryland ms 23s or 28s-f show	Funeral Director	1303 0	ld Mounta	ain Ro	ad			1085			USA			
	ner	11. Marital Status		12. Was Deced	dent Ever in U	J.S. 13.	Was Dece	dent of His	spanic Origin? (S n, Mexican, Puerl	pecify Yes or N		14. Race - Am		_
after or its		_	ried 2□ Married	1 ☐ Yes 2	2 🗆 No		1 ☐ Yes		Specify:	o rican, etc.)		Black, Wh		
	d by	3K☐ Widowed		Year or Da	tes:						1 4 5 1 4 1			_
1215-00 (1215-00 within 72 hours and then 'natural and and and and and and and and and and	Completed		15. Decedent's Edu cify only highest grad	le completed)		16a. Dece (Give life.	kind of wo DO NOT u	rk done d se retired)	uring most of wor)	rking		ind of Business	•	
d 212 dilled with Hygiene. out, the	шо	Elementary/Second 9th	ondary (0-12)	College (1-	4or 5+)	1	ainte				E	Eastwi	nd	
	Вес	17. Father's Name	(First, Middle, Last)						18. Mother's Nar	ne (First, Middle	, Maiden	Sumame)		
laryland 212 2 should be filed with and Mental Hygiene is marked other the aumatic event, that	길		n LaRicci						Mary I					
			lame/Relationship (7)	rpe, Print) / son		1	-		nd Number or Ru le Road				Zip Code)	
G, N. T. and Health Health	3	20a. Method of Dis		7 5011	20b. i	Place of Dispo	sition /Nar	ne of		Date	20c I o	cation - City o	r Town State	_
Baltimore, N permit. Pages 1 and Dopartment of Health Important; If them 27 eny injury or other tages.		1 🔀 Burial 2	☐ Cremation 3 ☐ F		state Ho	cemetery, crei DILY I	natory or d I i I I	ther place Cem	etery 5	5/20/06	Ba	ltimor	re	
Baltimor permit. Pages Department of Important: If it	H		uneral Service Licens		10				a of English					-
0 50 5 8		► K	Telry	(onn	celle	1	Conn	elly					lto.MD x 21221	
		23a. Part 1. Enter shock, or hea	the disease, or comp art failure. List only o	ications that ca	used the deat								Approximate Interval Between	
Physician		Immediate Cause disease or condition	(Final on	. (1	ODD		Stage						204 ears	
/Medical Examiner		resulting in death)		Due to (c	or as a consec		J						dog tars	-
	7	Sequentially list co	onditions,	b. One to fo	or as a consec	wence off								
nosit Lied	Examiner	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or	erlying r injury	200 10 (0	n us u sonsoc	quarios oi).								
18760, crate be executed physicien and site burial-transit	Exa	that initiated event resulting in death)	Last	Due to (a	or as a consec	quence of):								
8760, icate be ex physicien a the burial	dicai			d	·									
	a > 1	IF FEMALE:												
Box 6 eath certifications of the use as	an/	23b. Was deceder in the past 12	nt pregnant		th 2 ☐ Feta	al death 3	Ectopic p				2	23d. Date of de Month	livery Day Year	
P.O. I het the de de by the e	Physician/M	1 ☐ Yes 2 9 ☐ Unknown	□No	4∐Pregna 9☐Unknov	int at time of o wn	death 5∟	Other (sp	ecify)					,	
vision of Vital Records, P.O. Box (Attending Physicien: The law requires that the death certif death octor: After this certificate has been signed by the ettending by the funeral director, page 2 should be detached for use a		Part II. Other signi	ificant conditions co	ntributing to dea	ath but not res	sulting in the u	nderlying o	ause give	n in Part I.	23e. Did	tobacco u	se contribute t	o the cause of death?	_
Division of Vital Records, or attending Physicien: The law requires the fier death. Director: After this certificate has been signed in by the funeral director, page 2 should be death.	od by									1 🗇	Yes 2	□No 3 □ P	robably 4 Unknown	
aw requ	pleto									24a. Was		24b. Were a	utopsy findings available	_
II Re(The lav	Completed									auto perfe 1 ☐ Yes	ormed? 🗾	death?	completion of cause of 2 □ No	
Vital	Bec	25. Was case refe examiner?	/		/				26. Place of Dea					
Of \Physical Line coal direction	2	1 ☐ Yes 2 ☐	NINO			ER/Outpatier			4 🗆 Ivui sing n	ome 5 ☐ Res			ecify)	_
On On On On On On On On On On On On On O	ion:	27. Manner Dea 1 Latural	5 Pending	28a. Date of (Month	n, Day Year)	28b. Time of Injury	M 2	8c. Injury Work	at ? ′es 2 ∐ No	28d. Describe	how injury	y occurred		
Attens death death ctor:	ficat	2 Accident 3 Suicide	investigation 6 Could not be determined	28e. Place o	of Injury - At h	ome, farm, str			63 2 110	28f. Location /	Street and	d Number or R	ural Route Number.	_
Divisio	Certification:	4 🗌 Homicide	determined	buildin	g, etc. (Specia	fy)		,0		City or To	wn, State))	3.4	
	Medical (29a. Certifier (Check only one)	1☐ Certifying Phy 2☐ Medical Exami	sician: To the t ner: On the bas and manne	sis of examina	owledge, death	occurred vestigation	at the time in my op	e, date and place inion, death occu	, and due to the rred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)	
To the within 2 To the comple	Me	29b. Signature and	d title of certifier	ano maint			290	. License	number		29d. Date	e signed (Mon	th, Day, Year)	_
) (1)	0	1	2.7.0			Res	50000		51	19/00	€	
10		30. Name and add	dress of person who co	ompleted cause	of death (Iter	n 23a) (Type,	Print)							_
			arisse I	Davent	porth	ID 90	00 Fr	ank	lin Sque	are Dr	ive	baltin	nore, Md 2/23;	7
Stat Registra		31. Date filed (Mor	nth, Day, Year) AAY 2, 3, 201	32, Re	gistrar's Signa	ature	asis of	,					,	

			1 - For State Registrar	State of Ma	aryland .		irtment <i>tificate</i>			Mental Hy	/gier Reg. M	7111	36	168	203
	Physici		Decedent's Name (First, Middle, Last)							2. Date of D		Day	Year	3. Time of	Death
	/Medi		Morris	F.			mk y			May 1		2006	TOAI	5:02	РМ
	Examir	er	4a. Facility Name (If not institution, give s Millennium Healt	treet and number) :h & Rehal	hilita	tion	4b. City, To	wn, or Loca			4	c. County o	of Death		
			Social Security Number 6. Sex.		e (In yrs. last		If Under 1	Glen	Burni nder 24 Hr:			Anne			
	Funeral Director		220-22-6811	M 2□F	79	Yrs.		Days Ho		. (Month, D	ay, Yea			lace (State o	or Foreign
			Usual Residence of Decedent		_ / 3					March	Ц,_	1927	Mar	yland	
	how		10a. State 10b. County		10c. City, T								1	0d. Inside Ci	,
	Ba-1-	cto	Md. N/A			Balti	more							1 Yes	2 🗌 No
	vith th	Director	10e. Street and Number				10f. Zip C				10g. (Citizen of W	hat Coun	try?	
	hours after deeth with the Maryland turel', or Iteme 23e or 28e-f ehow al Examinar must be notified at	by Funeral	703 S. Robinson		Evenie II C	10.1	1	21224		2 11 11		USA			
	ter d	ů,	11. Marital Status 1 ☑ Never Married 2 ☐ Married	 Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ N 		13. V	Yes, specify	Cuban, Me	c Origin? (: xican, Pue	Specify Yes or N rto Rican, etc.)	5-		- Amenc , White,	an Indian, etc.	
93	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐Yes 20	No Spe	city:			Specify:	W	hite	
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7	within ene. then	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. E	O NOT use	retired)	most of we	nknig					
2	e filed within al Hygiene. I other then vent, the Me		17. Father's Name (First, Middle, Last)			<u>C1</u>	<u>erk</u>		4 .1 .1 .1			otels			
and	ad of	Be	Walter		Lamky	V				me (First, Middle	, Maide		•		
Maryland 21215-0036	2 should be and Menta Is marked eumatic ev	ဥ	19a. Informant's Name/Relationship (Typ	e. Print)	-	<u></u>	n Address /S		Hatti	ural Route Numb	er City		Ande		
	nd 2 lith a 27 le		Winifred Simms	, ,		1862	Pator	ac Rd	. Pas	adena, M	ld.,	2112	2	0004)	
Baltimore,	es 1 a of Hea fitem r othe		20a. Method of Disposition		20b. Place	of Dispos	ition (Name atory or othe	of	1	Date		Location - C		wn, State	
Ē	Pages nent of ant: If it ary or o		1 □Xurial 2 □ Cremation 3 □Re 4 □ Donation 5 □ Other (Specify)	moval from State			Cemete		5/2	2/06	Bal	timore	a. Mo	1.	
at	permit. Pages Department of Important: If it eny Injury or c		21. Signature of Funeral Service Clcens	1 10		22.	Name and A	Address of F	acility S	tallings	Fu	neral	Home	⊇ PA	
_	70F 2 9		Muschell D	alle	de					Pasaden		Md. 2	1122		
			23a. Part. Enter the disease, or complice shock, or heart failure. List only one	ations that caused cause on each lin	the death. D	o not ente	r the mode o	t dying, such	h as cardia	c or respiratory a	rrest,			Approximate Interval Bety	ween
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	La	CIUI	auro	1 /1	up						Onset and D	Jeath
	Examiner			Due to (or as a	a consequenc	ce of):		1							
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequent	ea of):							-		
1	ansit d	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events												
oʻ	e exec en ar irial-t	EX	resulting in death) Last	Due to (or as a	a consequent	ce of):									
8760,	cate be executed physicien and the burial-transit	dlcal	d.												
9	eath certific ettending p I for use as	/Med	IF FEMALE:												
Вох	ettend for us	lan	in the past 12 months?	c. If yes, outcome of 1 Live birth : 4 Pregnant at	2 Fetal dea	ath 3 🔲	Ectopic pregr					23d. Date Monti			ear ear
o	that the deatl ed by the ette detached for	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	time of death	2 1	Other (special	(y)						,	
۵.	The law requires that the death certificate be executed to the has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	by Physician/Me	Part II. Other significant conditions cont	ributing to death bu	ıt not resultin	g in the un	derlying caus	e given in P	art I.	23e. Did t	obacco	use contrib	ute to the	e cause of de	eath?
rds	w requires been sign should be	ed b	failure	to	100	ul				10	Yes 2	2 □ No 3	☐ Proba	ibly 480	nknown
ဝ၁	law requas been 2 should	plet								24a. Was		24b. W	ere autop	sy findings a	available
Ě	ysician: The lis certificate he director, page	Completed								auto perfo	rmed2	de	ath?	pletion of ca 2□ No	use of
/ita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	214 24-2				26. P	lace of Ce	ath Check only		120			
of	Physi this c al dire	P.	1 163 25 140	spital: 1 fnpatier				Other:	Nursing H	lome 5 ☐ Resi	dence	6 ☐Other	(Specify)		
L _O	ding l	io io	27. Manner of Death 1. □Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 28t	o. Time of Injury		Injury at Work?	O No.	28d. Describe	now inju	iry occurred	i		
Division of Vital Records,	Attending Physician: In death. •ctor: After this certific by the funeral director.	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ny - At home	farm etro	M factory of	1 ☐ Yes 2	2 NO	28f. Location (Stroot 2	nd Number	as Buml	Pourto Mumb	
<u>S</u>	after after Dire	Certification:	4 Homicide determined		City or To	vn, Stat	e)	or Aurar	HODIO IVUINE	rer,					
	ospite hours uners y fille		29a. Certifier 1□ Certifying Physi	cian: To the best o	f my knowled	ige, death	occurred at t	he time, date	and place	and due to the	cause(s	and manr	er as sta	ted.	
	To the Hospital or Attending Ph within 24 hours after death, To the Fureral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examine one)	or: On the basis of and manner stat	examination :	and/or inve	estigation, in	my opinion,	death occu	irred at the time,	date an	d place, and	d due to t	the cause(s)	
	Tot Tot Tot	Σ	29b. Signature and title of certifier				29c. Li	cense numb	er		29d. Da	ate signed (Month, D	ay. Year)	
ı	On I						L	570	028		5	5-10	7-6	06	
	"		30. Name and address of person who com	pleted cause of de	ath (Item 23a	a) (Type, P	ring	1100	1 /	Longer	10	IND	\sim 1	xhi	
	Sta	0	31. Date (iled (Month, Day, Year)	32 Begistra	r's Signature	yen	THU:	# 1	of t	major	W,	NIU	1	411	
	Registr		MAY 2 3 200		J. J.		10								

			For	State of Maryland			Mental Hygien	e o o o o	17001
			1 - State Registrar		Certificate of	of Death	Reg. N	~ UUb	16204
	Physicia /Medic		1. Decedent's Name (First, Middle, Las	Mecalla			2. Date of Death Month D	Pi 2006	3. Time of Death
1	Examin	9%	4a, Facility Name (If not institution, give	street and number),	tal BG	n, or Location of Death	00	c. County of Death	VA
	Funeral Director		5. Social Security Number 6. Social Security Number 6. Social Security Number 118-2663	7. Age (In yrs. last	birthday) If Under 1 Ye Months Da	ar If Under 24 Hrs.	8. Date of Birth (Month, Day Yea	9. Bifthp	lace (State or Foreign
	D D		Usual Residence of Decedent 10a. State 10b. County	10c. City, T.	own or Location		Ocist Ku,		0d. Inside City Limits
	e Maryi Ba-f eho	Director	Md N	1A B.	altimore				Yes 2□No
	h with th	ai Dire	Me Cooperati	ve Drive #	209 10f. Zip Cod	21212	10g. C	Citizen of What Cour	itry? 5A
36	a within 72 hours after death with the Maryland Jiene r than "natural", or Heme 23e or 28e-f ehow The Masical Evandrat must be rollified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent If Yes, specify 0	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	"natura "natura edical E	leted	15. Decedent's Ed (Specify only highest gra	ucation 1	6a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re	ne during most of work	ing 16b.	Kind of Business/Inc	dustry
	filed within Hygiene. other than and, the Mes	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Compani	on Nurs	se Ni	arsing Ao	ency
Maryland	be de la page	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Major	Sumame)	1
Mary	d 2 sho h and 7 Is m treum		19a. Informant's Name/Relationship		19b. Mailing Address (Str P.O. Box 20		al Route Number, City	or Town, State, Zip	Code)
ore,	Pages 1 and 2 nent of Health int: If item 27 iry or other tru		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	e of Disposition (Name of etery, crematory or other	place)		Location - City or To	wn, State
Baltimore	permit. Pages Department of I Important: If it any injury or o		4 ☐ Donation 5 ☐ Other (Specify 21. Signature Funeral Service Li		22. Name and Ad	tm 5/c	19/06 Jik	usville ,	Md. Home
ä			Merry Ha	lerels	5240 Reis	terstown	Rd Balt		121215
Kan	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. Metaslatic	Pancked	1.	or respiratory arrest,		Approximate Interval Between Onset and Death
4	/Medical Examiner			Due to (or as a consequen	ce of):				
7	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	ce of):				
8760,	te be executed ysicien and ie burial-transit	dicai Exa	resulting in death) Last	Due to (or as a consequen	ce of):				
9	rtificate ng phys	Medic	IF FEMALE:	d					
P.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 Ectopic pregna			23d. Date of delive Month	ny Day Year
	puires that the signed by ald be detacted	þ	Part II. Other significant conditions o	ontributing to death but not resulting	ng in the underlying cause	given in Part I.	23e. Did tobacco	use contribute to the	
Vital Records,	The faw requir ate has been si page 2 should	Completed					24a. Was an autopsy performed?	prior to cor	psy findings available inpletion of cause of
ital		0	25. Was case referred to medical			26. Place of Deat	1 ☐ Yes 2 N h (Check only one)	lo 1 Yes	2 No
	Physicien: r this certific ral director,	ToB	examiner? 1 Yes 2 No		Cutpatient 30 DOA		ome 5 Residence		/)
ion	Attending F death. ctor: After y the funera	atlon:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)		njury at Work? 1 Yes 2 No	28d. Describe how in	ury occurred	
Division of	of or Attend after death Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, off	ice	28f. Location (Street a City or Town, Sta		l Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my knowle iner: On the basis of examination and manner stated.	dge, death occurred at the and/or investigation, in n	e time, date and place, ny opinion, death occur	and due to the cause(red at the time, date a	s) and manner as st nd place, and due to	ated. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier		29c. Lic	ense number	29d. D	Pate signed (Month,	Day, Year)
	1		30. Name and address of person-who	completed cause of death (Item 23)	Ba) (Type, Print) -56 C	olloch C	aven 31	101,	
			DMitrix Pir	elis, M.D.	Ba	Himore,	MD 212	39	
	Sta Registr		31. Date filed (Montil, Day, Year)	32. Registrar's Signature	A Sparker				

			1 - For Stata Registrar	State of M	larylan		artment rtificate					ene g. No. 20	06	5	205
	Dhusis)	ij	1. Decedent's Name (First, Middle, Las	it)							2. Date of Deat Month	n Day	Year	3. Time of	Death
	Physicia /Medic		Alice Virginia								MA	Y 22, a	2006	2:40	A M
	Examin	er	4a. Facility Name (If not institution, give Saint Joseph			ter	4b. City,	Town, or	Location o	of Death	n	4c. County		imore	
			Social Security Number 6. S.			last birthday)	If Under	1 Year	If Under						
	Funeral Director			Chr offic	76	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Nov. 20	1929	Coun	ace (State of try) W Yor	.k
	р.		Usual Residence of Decedent		10a Cib	y, Town or Lo								Od. Inside Ci	
	shov	ō	10a. State 10b. County		100. 013	y, TOWN OF LO							11	od. Inside Ci 1. Yes	*
	the M	rect	Maryland N/A 10e. Street and Number				10f. Zip	<u>timo</u> Code	re		10	g. Citizen of W	/hat Coun	try?	
	3a or	<u>a</u>	4208 Ashland Ave	nue					21205	5			ı. s.		
	death	ner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.	S. 13.	Was Deced	ent of Hi			ecify Yes or No- Rican, etc.)	14. Race	e - Americ k, White, e	an Indian,	
36	or Ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 🕱	No		1 ☐ Yes 2		Specify:	,		Specify		hite	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23a or 28a-1 show the Madical Exemirar must be notified at	Completed by Funeral Director	3 ☐Widowed 4 ☑ Divorced 15. Decedent's Ed	Year or Dates	:	16a. Dece	fent's Usua	l Occuna	ation			6b. Kind of Bu			
7	n "na	plet	(Specify only highest gra	de completed) College (1-40)	(5.1)	(Give	kind of wor DO NOT us	k done a	luring most	t of worki	ng	op. rand or bu	01110331110	ustry	
212	giene giene r the	E O	Unknown	- Conego (1-40)	3+)		Su	perv	isor			Ca	bete	ria	
n	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)						18. Mothe		(First, Middle, N		e)		
S	nould I Men narke	ို	Richard Frank			105 14-10		(5)			iginia S	- 00-2	C+++ 7'-	0-4-1	
<u>B</u>	d 2 sh th and t7 is n traun		19a. Informant's Name/Relationship (19a) Ginger Tudor (Day)	· .							i Route Number. altimor(-			
re,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat rulat be natified at an once.		20a. Method of Disposition		20b. P	lace of Dispo						Oc. Location -			
Baltimore,	Page: nent o nt: If ry or		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		8					5/24	/2006 L	aurol_	Мали	land	
alti	permit. Departm Imports any inju	-	21. Signature of Funeral Service Licen	see .	b	22	. Name and	d Addres	s of Facilit	y Sch	rimunek	Funeral	Home	2 Inc.	
<u>-</u>	90E # 9		Defanie	Kone	Res	3	331 B	rehm	is Lav	re, t	Baltimor	e, Mary	land	21213	3
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that cause one cause on each	ed the death line.	n. Do not ent	er the mode	of dying	g, such as	cardiac c	r respiratory arre	st,		Approximate Interval Bet Onset and I	ween
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	v			DLE C	CERE	EBRAL	_ AR	TERY I	VFARCT	•		
	Examiner			Due to (or a			ARCTI	I ON							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a											
	cuted nd rransit	Examiner	that initiated events	c. ACUTE			ILURE								
760,	ate be executed hysician and the burial-transit	I Ex	resulting in death) Last	Due to (or a	s a consequ	uence of):									
687	physicate I	dical	•	d											
X	nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			-					23d. Date	of delive	y	
.O. Box	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 Q No	1 □ Live birth 4 □ Pregnant : 9 □ Unknown			Ectopic pre Other (spe					Mor	nth	Day 1	rear
<u>о</u>	Physician: The law requires that the death certifica this certificate has been signed by the attending ph rai director, page 2 should be detached for use as t	Physician/Med	9 Unknown				- 11								
ທົ	res th signed	by	Part II. Other significant conditions of	ontributing to death	but not resu	ulting in the u	nderlying ca	ause give	n in Part I.			acco use contr s 2 □ No	ibute to th 3 🗌 Proba		leath? Jnknown
Record	w requir been si should	Completed												/ '	
Bec	he fav s has ige 2 :	mpl									24a. Was ar autops perform	ed? d	rior to con eath?	sy findings a	
Vital	an: T tificate tor, pa	a	25. Was case referred to medical						26 Place	of Death	1 Yes 2		☐ Yes	21 A No	
Ţ	ysici lis cer direct	To B	examiner? 1 □ Yes 2 No	Hospital: 1 1 Inpai	tient 2	ER/Outpatier	it 3□ DO	A Othe	\r.		me 5 Reside		er (Specify)	
0	ding Physician: The lav h. After this certificate has funeral director, page 2		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of In (Month, D	jury Jay Year)	28b. Time of Injury		Bc. Injury Work	:?		28d. Describe ho	w injury occurre	ed		
Sio	Attending ir death. ector: Alter by the fune	cat	2 Accident investigation 3 □ Suicide 6 □ Could not be		aiva. At ba		M		/es 2 □!		184 Lagation /Ct	ant and Aliceb		Clause Nove	
Division of	l or Attendater deatl Director:	Certification:	4 Homicide determined	28e. Place of to building, e	etc. (Specify	me, rarm, str	eet, ractory,	, опісе		1	28f. Location (<i>Str</i> City or Town	State)	er or Hurai	Houte Num	Der,
	To the Hospital or Attan within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Cartifying Ph	ysician: To the bes	it of my kno	wledge, deatl	n occurred a	at the tim	e, date an	d place, a	and due to the ca	use(s) and mar	ner as sta	ated.	
	he Ho in 24 I he Fu pletely	edical	(Check only 2 Medical Examone)	niner: On the basis and manner s	of examinet stated.	tion and/or in	vestigation,	in my op	pinion, deat	th occurr	ed at the time, da	te and place, a	ind due to	the cause(s)
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•			> goginder 1) 41	410		100	194 22	nd,	200	Ь '
	2		30. Name and addr s of person who				·	\ p\ = 1	g germ maga yan	գ լ յաս, ա.	ki kammin	PAR ENT	. سیری		
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	ture		NKTA	<u> </u>	UEWL	N_MARYI	HND S	1204	·	
	Registr		MAY 2 3 200		a Lie	Special	N. D.								

Physician /Medical Examiner Aa. Facility Name (If not institution, give street and number 1998)	Ce	ertificate of l	Doath			
/Medical Examiner 4a. Facility Name (If not institution, give street and number)				2. Date of Death	Day Year	3. Time of Death
	Der)	4b. City. Town, or	r Location of Death	May 21,	2006	11:30 AM M
308 Dale Avenue		I	Baltimore		Baltimore	
Director 216-14-0312 1 M 2 F	. Age (In yrs. last birthda) &3 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 01/04/1	9. Birtl 923 MD	nplace (State or Foreign untry)
Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
MD Baltimore	Baltimor	е				1 □ Yes 2 No
10e. Street and Number 10e. Street and Number 308 Dale Avenue		10f. Zip Code 21206			g. Citizen of What Co nited Stat	
11. Marital Status 12. Was Deceded Armed Force	ces? 2•☑No	B. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.
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4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	-	22. Name and Addres Cremation a 8717 Green				ryland 21286-
/Medical resulting in death) Examiner Due to (o	used the death. Do not e ch line. H FTCC 5C LC r as a consequence of):		g, such as cardiac or	respiratory arrest	t,	Approximate Interval Between Onset and Death
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A NEM A 25. Was case referred to medical examiner? 1 Yes 2 DNo Hospital: 1 In			26. Place of Death		ZNo 1 ☐ Yes	2 No
_ × Ø 0 0 1 Tes 202No	patient 2 ER/Outpati		4 Nursing Hom	ne 5 Vesidend 8d. Describe how	ce 6 ☐Other (Spec	ify)
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2 Page 1 and Louring	of Injury - At home, farm, s g, etc. <i>(Specify)</i>	street, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
Service of the policy one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Medical Examiner: On the base and manner.	sis of examination and/or	ath occurred at the tim investigation, in my of	ne, date and place, a pinion, death occurre	d at the time, date	and place, and due	to the cause(s)
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30. Name and address of person who completed cause JEHRELY SCHULTZ MD 8 31. Date filed (Month, Day, Year) 32. Re-	of death (Item 23a) (Type STAIR gistrar's Signature	RD BAL	17740726	MOD Z	21236	

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State

Registrar

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State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. -2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** May 1:33 P M 2006 Shirley Ann Mooney /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 7, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2√□ F 70 WI 391-32-6292 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Assist: If tem 27 is marked other than "naturel", or iteme 23s or 28s-1 show ant; If tem 27 is marked other than "naturel", or other traumatic event, the Marical Examiner must be notified at any or other traumatic event, the Marical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 → No MD Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā 21060 USA Funerai 110 Alview Terr. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 SWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kenneth Clark Irma Jauquet ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3420 Spring Azure Ct.; Edgewater, MD 21037 Mrs. Susan Crumrine/Daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition MD veterans Cemetery May 23, 2006 Crownsville, MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Important: If eny injury or once. 21. Signature of Fundral Service Licensee 22. Name and Address of Facility 1 Second Ave. SW M01411 Singleton Funeral Home, Glen Burnie, MD 21061 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART Attack **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed the attending physicien and the for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown cete has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Artery Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 KInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 2 this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) read Beach, Mb D46052 5 18/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Brint)

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	To the within To the comple	Me	29b. Signature and title of certifier	4	and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of th	290	. License	number		29d. C	Date signed	i (Month, E	Day, Year)
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	1		30. Name ddr of person who co					A	0	. ^	7	1	
	- 510	to	DALJEET SP 31. Date filed (Month, Day, Year)	LUJ A	rar's Signature	600 h	rest	MT	- 164C	(Ac	re Ba	1+ M	D 21217
	Sta Registr		MAY 2 3 2	27	. At	Scorte	,						

ORIGINAL

			1 - For State Registrer	State of Ma		d / Depa		Health and M	•	/giene	nns	16210
			Registrer 1. Decedent's Name (First, Middle, La	etl		Oei	illicate Of	Dealii	2. Date of De	Reg. No.	UUU	3 Time of Dooth
	Physici	an	1. Decedent's Name (Pirst, Middle, La			Ī.	- 1		Month	Day	Year	3. Time of Death
	/Media		KEVIN	LEE		Mu			MAY	71	2006	JOOZ AM
	Examir	er	4a. Fecility Name (If not institution, giv	e street and number)		,	4b. City, Town, o	or Location of Death	10 .	4c. Co	ounty of Deati	1
			/ he Johnstop	laws Ho:	pito	1	Balt	mone (1/4			
	Funeral		·	Sex 7. Agr		ist birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	irth ay, Year)	9. Birth Co.	nplace (State or Foreign untry)
	Director		217-23-3434	X W 201	1	6 Yrs.				1989	MAR	YLAND
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	agtion					10d. Inside City Limits
	shor	-		т т	_							1√2 Yes 2 □ No
	8e-f	octo	MD CARRO	ســـــــــــــــــــــــــــــــــــــ		TANEY						
	ith th	100	10e. Street and Number				10f. Zip Code				n of What Co	untry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23a or 28e-f show ther, the Medical Examinar must be notified at	Funeral Director	226 MARYLAND A				2178			USA	7	
	e use	ne	11. Marital Status	12. Was Decedent Armed Forces?		3. 13.	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	0- 14.	Race - Amer Black, White	
9	afte or It		1 X Never Married 2 Married	1 ☐ Yes 2X11 If Yes, Give	10	1	I∐Yes 2⊠No					
21215-0036	irei',	d b	3 Widowed 4 Divorced	Year or Dates:							WH.	ITE
5	72 r	ete	15. Decedent's E (Specify only highest gra			16a. Deced (Give	lent's Usual Occup kind of work done	pation during most of world)	king	16b. Kind	of Business/I	ndustry
7	within ene. than '	ф	Elementary/Secondary (0-12)	Coilege (1-4or 5	+)	life. I	_					
	filed w Hygier Ither th	Completed by	10				STUDENT				ATION	
pu	tal H d off	Be	17. Father's Name (First, Middle, Last					18. Mother's Nam	e (First, Middle	e, Maiden Su	ımame)	
<u>K</u>	should tind Ment	၉	EUGENE	ARNOLD	MULL	OY, J	R.	VIRGIN	IA MAE	E IBE	X	
Maryland	2 sho and is mu		19a. Informant's Name/Relationship (g Address (Street	and Number or Ru	ra <i>l R</i> oute Numb	oer, City or T	own, State, Z	ip Code)
	1 and 1 Health em 27		VIRGINIA ARMSTI	RONG -MOT				D AVE.,	TANEYT	OWN,	MD 2	1787
ore	of He roth		20a. Method of Disposition 1 ☑Burial 2 ☒ Cremation 3 ☐	Damoual from State	20b. Pla	ace of Dispo metery, crer	sition (Name of natory or other pla	ce)	Date	20c. Locat	tion - City or 1	Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28e-f show enviruity or other treumatic event, the Medical Examinar must be notified at Once.		'4 Donation 5 Other (Special		TT C	COUNT	Y CREMA	TION 5/	26/06	SYKES	VILLE	, MD
a	mit. partn sorts / inju		21. Signature of Funeral Service Lice	nsee		22	. Name and Addre	ess of Facility FL	ETCHER	FUNF	RAL H	OME
m	Depar Impo							AIN ST.				D. 21157
	-		23a. Part1. Ent + th - disease, or com shock, or lead failure. List only	plications that caused	the death.						- T	Approximate Interval Between
	Dhusisian		Immediate Caus (Final	one cause on each iir	10.	100		107211 (200	200	170	1	Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue to (or as	SMMS		MUSCUL	MC Dys	TROP	-14	-	10 years
	Examiner			200 10 (01 00	a consequ	01100 017.						
		e.	Sequentially list conditions, it is a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a conseque	ence of):						
	nsit	벁	cause. Enter Underlying Cause (Disease or injury									
	be executed ician and burial-transit	Examin	resulting in death) Last	Due to (or as	a conseque	ence of):						
760,	es that the death certificate be executed igned by the attending physician and be detached for use as the buriat-transit	caiE										
687	phys s the			_ d								
×	ding se a	/Me	IF FEMALE:	23c. If yes, outcome	of pregnan	icv				004	D-46 d-1	
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic pregnancy Other (specify)	у		230	 Date of deliver Month 	rery Day Year
-	the d	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	time or dec	2(1) 5	Culer (specify)					
P.0	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Ph	Part II. Other significant conditions of	contributing to death be	ut not resul	ting in the ur	derlying cause gry	ven in Part I	23e. Did	tobacco use	contribute to	the cause of death?
Records,	signe signe d be	Completed by	CARDIOMYOPA				, , g g			Yes 2 N		bably 4 □Unknown
9	w require been si should I	etec	-13-213-1017							103 213		
ec	alaw has b e 2 s	npi				·			24a. Was auto	DSV	prior to co	opsy findings available ompletion of cause of
H	The sate pag	So								ormed? 2621No	death? 1 ☐ Yes	200 No
Vital	Physicien: The law this certificate has b ral director, page 2 s	Be	25. Was case referred to medical examiner?					26. Place of Deal	h Check on	one		
of \	Physic this c	2	1 ☐ Yes 2 X No	Hospital: 1 Inpatie	nt 2□E	R/Outpatien	t 3 DOA Oth	19r: 4 ☐ Nursing Ho	ome 5 Resi	idence 6 🗆	Other (Spec	ify)
n c	ding P	:uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	28c. Injur Wor	ry at rk?	28d. Describe	how injury or	ccurred	
.0	Attending r death. sctor: After by the funer	ati	2 Accident investigation				M 1	Yes 2 □ No				
Division	r Att	ţij	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ry - At hon (Specify)	ne, farm, str	eet, factory, office			Street and N wn, State)	lumber or Rui	al Route Number,
	rs aft	Certification:		l l								
	hou hou uner	edicai	29a. Certifier 1 Certifying Pt	nysicien: To the best of miner: On the basis of	of my know	rledge, death	occurred at the tir	me, date and place,	and due to the	cause(s) and	d manner as	stated.
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edi	oney	and manner sta	ted.	on and or m		opinion, death occur	red at the time,	date and pla	ice, and que	o the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier				29c. Licens			29d. Date s	igned (Month,	Day, Year)
	/		Church	1.16	-10	\sim	RES	5-000)	5.Z	1.06	
6	0		30. Name and odress of person who	completed cause of d	eath (Item :	23а) (Туре,						
1			JULE WILLAMSON,	DO 600		JOLFE	STREET	BALTIMO	M 390	OZ	7851	
	Sta		31. Date filed (Month, Day, Year)	32. Redistra	ır's Signatu		mile					
	Registi	ar	MAY 2 3	2008	College .	M. A.	A STATE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PAR					

			For State Registrar	State of Ma	arylan				lealth a D <i>eath</i>	and M	ental Hy	giene Reg. No	1 U I	96	16211
1/2			1. Decedent's Name (First, Middle, La	st)							2. Date of De Month	ath Da	v	Year	3. Time of Death
	Physici /Medi		Apollonia Marie	Munter							May 22	2, 20	06	real	8:05A M
	Examir		4a. Facility Name (If not institution, given				4b. Cit	, Town, or	Location o	f Death		4c.	County	of Death	
			Rockville Nursi	ng Home				ckvi				1	lont	gomer	
	Funeral			Sex 7. Ago 1 ☐ M 2 反 F	e (In yrs. I	last birthday)	tf Und Months	or 1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	ay, Year)			place (State or Foreign ntry)
	Director		292-30-8192	- X	97	Yrs.					April	24,	1909	Ohio)
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation					-		1	0d. Inside City Limits
	danyl f sho	5	Maryland Montgon		Doo	kville									1 ☐ Yes 2 X No
	the t	Director	10e. Street and Number	lery	KUC	KVIIIE	1	ip Code		-		10g. Cit	izen of V	Vhat Cour	ntry?
	be filed within 72 hours after death with the Maryland lat Hygiene. d other then "natural", or itsms 23a or 28a-f show svent, tra Medigal Exercitar must be notified at	ā	1112 Fallsmead Wa					20854	·.			Uni	tod.	Stat	0.0
	ms 2;	Funeral	11.12 FallSillead Wa	12. Was Decedent I	Ever in U.	S. 13. \	Vas Dec	edent of Hi	ispanic Orio	gin? (Spe	cify Yes or No		14. Rac	e - Americ	an Indian,
0	r Its		1 ☐ Never Married 2 ☐ Married	Armed Forces?	lo				n, Mexican	, Puerto I	Rican, etc.)			k, White,	etc.
3	al', o	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			Yes	2 ∏ №	Specify:				Specify		nite
ך מ	72 ho	Completed	15. Decedent's E			16a. Deced	ient's Us	ual Occupa	ation during most	of workii	na	16b. K	ind of Bu	isiness/in	dustry
V	ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. I	DO NOT	use retired)		,				
Z	filed w Hygier other th	S		4		Ins	truc	tor						tion	
	tal H d oth	Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle	, Maiden	Sumam	Θ)	
<u>X</u>	2 should be and Mental Is marked o	2	Nicholas Miller								rie Sc				
Maryland 21215-0036	ind 2 should talth and Ment 27 is marks or traumatics		19a. Informant's Name/Relationship	•		1					l Route Numb	•			Code)
	as 1 and of Health Item 27	1	Barbara A. Schar	f/Daughter		1112	Fa1	1smea		-	ckvi11				20854
5	Pages 1 nent of H int: if Ite		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 E	Removal from State	Ga:	emetery, crer te of	natory of Heav	other plac	(e) M	lay 2	25,	20c. Li	ocation -	City or 10	own, State
	Pa tmen tent:		4 ☐ Donation 5 ☐ Other (Speci			Cemet	erv		2	2006		Si1	ver	Spri	n, MD
Baltimore,	permit. Page Department of Important: ff any injury of		21. Signature of Funeral Service Lice	13.	500	Ro	. Name :	i11e,	ss of Facility Inc.	9 Rob 300	ert A. West 1	Pum	phre	y Fu	neral Home, venue
_	0 0 7 € 0		Jewse,	ery.	MO	0803 R	ockv:	ille,	Mary	land	_ 2085	0-28	5	1	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	pplications that caused one cause on each lir	the death	n. Do not ent	er the mo	de of dyin	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Finat disease or condition	a. Conges	tive	Heart	Fai	lure							1 Month
	/Medical Examiner		resutting in death)	Due to (or as								_			
	Examiner	L	Sequentially fist conditions,	b											
	ed slt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	а сопѕеді	uence or):									
_	cate be executed obly sician and the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of);									
09/8	be e	aiE	l l	v .	·	,									
ğ	phys phys s the	dicai		d											
×	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transle	Physician/Me	IF FEMALE:	23c. tf yes, outcome	of pregna	incy							23d Dat	e of delive	201
ğ	atter I for u	clar	23b. Was decedent pregnant in the past 12 months? 1 \(\sum \text{Yes} \) 2 \(\overline{\text{Q}}\) No	1□Live birth 4□Pregnant at			Ectopic Other (pregnancy specify)					Mo		Day Year
oj.	the d y the	ıysı	1 □ Yes 2 22No 9 □ Unknown	9□ Unknown				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
7	res that the de signed by the a be detached f	y P	Part II. Dther significant conditions	contributing to death b	ut not resu	utting in the u	nderlying	cause give	en in Part I.		23e. Did	obacco	use conti	ribute to th	ne cause of death?
SD	uires sign	d by	Diabetes								10	Yes 2	No	3 🗌 Prob	abiy 4 [Unknown
Ö	w require been si should b	lete	A								24a. Was	an	24h \	Vere auto	nsy findings available
Records,	: The law cate has	Completed	Anemia								auto	psy omed?		leath?	psy findings available mpletion of cause of
VII			25. Was case referred to medical	T					20.51	(D	1 Yes	2 🔀 No	1	Yes	2 No
	eician: certifica	9 Be	examiner?	Hospital:	-t 2[]	ER/Outpatien	t 3 🗆 [Othe	00		(Check only		c (70#		
o	Phys or this oral di	To T	27. Manner of Death	28a. Date of Inju		28b. Time of		28c. Injun	- W 1401		ne 5 Resi				у)
0	th. : After s funer	tion	1 ☑ Anatural 5 ☐ Pending 2 ☐ Accident investigation		y Year)	Intury	М		k? Yes 2∐1	No					
DIVISION OF	er death	Certification:	3 ☐ Suicide 6 ☐ Could not b	289. Place of Inju	ury - At ho	ome, farm, str	eet, facto	ry, office		2	28f. Location (Street ar	nd Numb	er or Rura	I Route Number,
Ē	al or afte Dire	ert	4 Homicide determined	building, etc	c. (Specify	y)					City or To	wn, State	9)		
	splta nours nera / fille		29a. Certifier 1 X Certifying P	hysician: To the best	of my kno	wiedge, death	occurre	d at the tim	ne, date and	d place, a	and due to the	cause(s	and ma	nner as s	tated.
	P Ho	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examina ited.	tion and/or in	estigation	n, in my of	pinion, deat	th occurre	ed at the time,	date and	d place, a	and due to	the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	ž	29b. Signature and title of certifier				2	9c. License	e number			29d. Da	te signe	(Month,	Day, Year)
}	1		Marinta	41 dos				D31	630			Mar	v 22	, 200	06
	Ď		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type,	Print)	ונע	933			-14	,	,	
	10		Christopher Dun			5 West	Mon	tgome	ry Av	enue	, Rock	vill	e, M	arv1:	and 20850
	St	ate	31. Date filed (Month, Day, Year)	3 Registra		ture	Al. I								
42	Regist	rar	MAY 2, 2, 20	16 BAR GAR	J Sid	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	-								

			For State Registrar	State of Maryla			of Death		g. No.	06	16212
	Physic		1. Decedent's Name (First, Middle, Last) Jennifer F.	Muh]				2. Date of Death Month	Day	Year	3. Time of Death 4. 35 A M
	/Medi Examir		4a. Facility Name (If not institution, give				n, or Location of Death	ICA	4c. County	of Death	
			BALTIMORE WASHING				Burnie		ANNE.		
	Funeral Director		5. Social Security Number 6. Sec. 114-56-1460	M OVE	7 Yrs.	If Under 1 Y Months Da		8. Date of Birth (Month, Day, April 04	Year) 1949	9. Birthp Cour	lace (State or Foreign htry)
	pu 🛦		Usual Residence of Decedent 10a, State 10b, County	10c. C	ity, Town or Loc	ation				1	0d. Inside City Limits
	ith the Maryland or 28a-f ehow	5			.,,		Dacadona				1 ☐ Yes 2 ☑ No
	the A 28a-1 noulli	Director	Maryland Anne Arur	iuei		10f. Zip Coo	P <u>asadena</u> ••	10	Og. Citizen of V	Vhat Cour	ntry?
6,	th with 23a or		4320 Mountain Roa	ıd			21122			USA	
+ - 1	deeth	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. W	/as Decedent	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No-			can Indian,
duhly Jennifer	1215-0035 within 72 hours after deeth with the Maryland ane. then "natural", or iteme 23a or 28a-f ehow the Maryland Experient material Experient and the medical Experient and the medical Experient and the medical Experient and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and the medical Experience and Experience and Experience and Experience and Experience and Exp	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes 2		7 1021, 510.7	Specify		hite
1	72 hours	ted	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	ent's Usual O	ccupation one during most of work	ina	16b. Kind of Bu	usiness/Inc	dustry
3	ING 21215-0 be filed within 72 ho htal Hygiene. d other then "natur event, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use re	etired)	,,,,	_		
3	d 21 filed w Hygien stherth	ပိ	12		Sa	ales As	SSOCiate 18. Mother's Nam	o /First Middle A		tail	
-	laryland 212 2 should be filed within and Mental Hygiene, le marked other then eumatic event, the M	Be C	17. Father's Name (First, Middle, Last) James Gauss				Mildre		olev	10)	
	re, Maryla s 1 and 2 should f Health and Men ltem 27 te marke other treumatic	ြ	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailing	g Address (St	reet and Number or Rur			State, Zip	Code)
	Malth a alth a 27 le		Charles A. Muhl	(spouse)	4320	Mounta	ain Road, P	asadena.	MD 211	22	
	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	1	Place of Dispos cemetery, crem	ition (Name o	of		20c. Location -		own, State
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	Baltimore, Maryland 21215-5-0036 permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Importent: if tiem 27 ie markad other then "natural", or eny liquy or other treumatic event, the Mudical Examplene.		21. Signatur of Funeral Struce Licens	Sh)			odress of Facility Ountain Roa	Stalling d. Pasad	s Funer	ral H	ome, P.A.
		Г	23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	cations that caused the dea							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		iz Bu	22AS.	T ELANCE	ER.			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse							
	Examiner	_	Sequentially list conditions,	Due to (or as a conse	Account of the						
W	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a sories	rquarica orj.						
V	58760, icate be executed physicien and s the burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
	68760, ilicate be ex physicien ss the buria	edical		J							
	fifficat rifficat ng phy es th		IF FEMALE:								
	Box (eath certif	an/h	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregi 1 ☐ Live birth 2 ☐ Fe	tal death 3 🗌	Ectopic pregn			23d. Dat Mo	te of delive	ory Day Year
	P.O. F	Physician/M	1 Yes 2 No	4□Pregnant at time of 9□Unknown	death 5□	Other (specif	y)				
	IS, P.O. BOX res that the death certigned by the attendin	y Ph	Part II. Other significant conditions con	ntributing to death but not re	esulting in the un	derlying caus	e given in Part I.	23e. Did tob	acco use cont	ribute to th	ne cause of death?
	rds quires on sign	ed by						1 □ Ye	s 2 No	3 ☐ Prob	pably 4 Unknown
	Division of Vital Records, P.O. Box (t or Attending Physiclan: The law requires that the death certif efter death. Director: After this certificate has been signed by the attending I in by the funeral director, page 2 should be detached for use e	Completed						24a. Was ar	v / r	Were auto	psy findings available mpletion of cause of
	The The page	Con						perform 1 ☐ Yes 2		death? I □ Yes	2□ No
	Vital Fideliclan: The certificate	Be	25. Was case referred to medical examiner?	lospital:			Othor	h (Check only on			
	On of Vital Reding Physician: The law h. After this certificate has timeral director, page 2	2	1 ☐ Yes 2 ☑ No 27. Mann of Death	28a. Date of Injury	☐ ER/Outpatient 28b. Time of			ome 5 Reside			y)
	On On oding I	tlon	1 ✓ atural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м	Injury at Work? 1 ☐ Yes 2 ☐ No	200. 2000.120 110	(2.)		
	ViSI Atten	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At building, etc. (Spec		et, factory, of	fice	28f. Location (St. City or Town		er or Rura	al Route Number,
	Las or sette	Cert	Tronnoido	bundary, etc. (Spec	y/			ony or roun	, ciulo)		
	Hoep! 24 hour Funer tely fill	edical		sician: To the best of my kinar: On the basis of examinand manner stated.							
	• '* • 0	豆				1			0.1.5		
_	To the within 2	Medi	29b. Signature and titte of certifier			29c. Li	cense number	2	9d. Date signer	d (Month,	Day, Year)
	Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ti	Medi	29b. Signature and title of certifier	-90	mes	296. L	45149	1	^		
	To the within 2	Medi	29b. Signature and title of certifier 30. Name and address of person who co	ampleted cause of death (Its	em 23a) (Type, F	D	Then b	wrie	^		Day, Year) LDDG

			For State Registrar	State of Maryland / Department of Health a Certificate of Death	6111	6 16213
			Registrar Decedent's Name (First, Middle, Last)	Sertificate of Beatif	Reg. No. 2. Date of Death Month Day Year	3. Time of Death
	Physici /Medio		Barbara	Nelson	Month Day Year 20 OC	0 8:25 PM
	Examin Funeral Director		191-16-6482	ulti-Care Center Baltim	ore No	ath I I I I I I I I I I I I I I I I I I I
	r 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location Baltimore		10d. Inside City Limits 1 ▼Yes 2 □ No
	with the Page or 28a-	Funeral Director	10e. Street and Number	C+ Apt. 101. Zip Code 2/201	10g. Citizen of What C	Country?
920	within 72 hours after death with the Maryland ane. than "natural", or items 23e or 28e-f show ta Madical Examilian must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican If Yes, sive Year or Dates: 1 Yes 2 No Specify:	gin? (Specify Yes or No- Puerto Rican, etc.) 14. Race - Am Black, Wh	
21215-0036		Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	of working 16b. Kind of Busines	s/industry
Maryland 2	should be filed nd Mental Hygin marked other imatic event, I	To Be C	17. Father's Name (First, Middle, Last) Green Ja	ckson Fro	r's Name (First, Middle, Maiden Sumame)	/
	1 and 2 s Health ar tem 27 is		19a. Informant's Name/Relationship (Ty Mrs. Charlotte 20a. Method of Disposition	Clark 5643 Govan	r or Rural Route Number, City or Town, Statel Pale 20c. Location - City o	1d, 21212
Baltimore,	permit. Pages Department of Important: If is any injury or o		1 X Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Maryland National -	126/2006 Laurel	Md.
8	90 11 10		23a. Part Enter the disease, or compli	2222 W. North cations that caused the death. Do not enter the mode of dying, such as a	Ave. Balto Md.2	216
	Physician /Medical		shock or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	END STAGE DEMENT		Approximate Interval Between Onset and Death
60,	cate be executed physician and the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): CEREBRO VASCUUAR Due to (or as a consequence of): Due to (or as a consequence of):	DISEASE	mouths you
68760,	phy:	edicai				
.O. Box	law requires that the death certific as been signed by the attending r 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 25 No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1	23d. Date of de Month	elivery Day Year
Ω.	w requires that been signed b should be deta	by	Part II. Other significant conditions cor	tributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute 1 ☐ Yes 2 ☐ No 3 ☐ F	to the cause of death?
al Records,	The ate his page	Completed			24a. Was an autopsy performed? death?	
of Vital	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{Yo} \)		of Death <i>(Check only one)</i> sing Home 5 Residence 6 Other <i>(Sp</i>	ecify)
ion of	ding Ph I. After th funeral	ation: T	27. Manner of D th 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 N	28d. Describe how injury occurred	,,
Division	i i i	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or F City or Town, State)	
	E Hospital 24 hours a Funeral I etely filled	Medical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	ician: To the best of my knowledge, death occurred at the time, date and ler: On the basis of examination and/or investigation, in my opinion, death and manner stated.	d place, and due to the cause(s) and manner a th occurred at the time, date and place, and du	s stated. e to the cause(s)
	To the vithin To the comp e	Me	29b. Signature and title of certifier	. Vally D2564	29d. Date signed (Mon	
-	4		30. Name and address of person who co Kendoll R Fruil in	mpleted cause of death (Item 23a) (Type, Print) er MD/10505 N. Chaules St/Suu 32. Régistrar's Signature	te 201/ Roots MD	51304 9006
	Sta Registr		31. Date filed (Month, Day, Year) MAV 2 3 2006	32. Registrar's Signature	/ 02.0	

			1 ← For State Registrar	State of Maryl		epartme <i>Certifica</i>				ene 200 g. No.	6 62		
	Physici /Medic		1. Decedent's Name (First, Middle, La: BETTY W. OUTI						2. Date of Death Mayonth 21	, ^D 2006 Year	3. Time of Death 9:30 A M		
	Examin		4a. Facility Name (If not institution, give Manor Care Rus			4b. Cit		Location of Deat	٦	4c. County of Dea Bal	timore		
	Funeral Director		5. Social Security Number 6. S 219-22-2487 1		yrs. last birtl	rs. If Und	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 5,	9. Bi	rthplace (State or Foreign ountry)		
	D		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town	or Location					10d. Inside City Limits		
	Maryla a-f ehov	ctor		ltimore	. Oily, TOWII	Nott	ngha	am			1 ☐ Yes 2 No		
	a with the	i Director	10e. Street and Number 9406 Seven Co	ourts Drive	9	10f. 2	ip Code 212	236	10	g. Citizen of What C	ountry? SA		
920	72 hours after deeth with the Maryland "naturel", or Reme 23s or 28s-f ehow Idhal Examiner must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	in U.S.	13. Was Dec If Yes, sp		ispanic Origin? (S in, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	encan Indian, te, etc. White		
215-0036	2 5 2	eted	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a.	Decedent's Us (Give kind of v	ual Occup	ation during most of wor	tking 1	6b. Kind of Business	/Industry		
121	within then then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Homer				At Hom	е		
yiand	id be filed ental Hygis ked other ic event, I	To Be C	17. Father's Name (First, Middle, Last) Lee M. Woolst						ne (First, Middle, M Clara Mo				
Mary	d 2 should th and Men ?7 ie marke treumatic	-	19a. Informant's Name/Relationship (Susan Price-Dau							City or Town, State,	Zip Code) m , MD 21236		
Baltimore,	Pages 1 and nent of Health int: If Item 27 iry or other ti		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification)	Removal from State	ob. Place of cemeter, Evans	Disposition (N Commatory of Funeral El-Air	ame of other place Chape	ť 5-2		Oc. Location - City of			
Balt	permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service Licer	ne tadde		22. Name	and Addres	ss of Facility EVA	ANS CHAP	EL OF MI	EMORIES 21234		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do n	ot enter the me	ode of dyin	g, such as cardiad	or respiratory arres	st,	Approximate Interval Between		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Cercbr	ovus	cular		acciden	F		Onset and Death		
	Examiner		Huarxtenain										
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
58/60,	ificate be executed physicien and is the burial-transit		resulting in death) Last										
_	- O 6	Medical	IF FEMALE:										
C. Box	at the death certif by the ettending tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr. 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death	3 □Ectopic 5 □ Other (23d. Date of de Month	livery Day Year		
ds, r	es the	ρ	Part II. Other significant conditions of	ontributing to death but not	t resulting in	the underlying	cause give	en in Part I.		acco use contribute t	o the cause of death?		
Vital Records,	The law requir	Completed		· · · · · · · · · · · · · · · · · · ·					24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of		
<u>E</u>		BeC	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes 21 ath (Check only one	INo 1 □ Yes	5 2 No		
> 	Physic this ca al direc	၉	examiner? 1 Des 2 No	Hospital: 1 ☐ Inpatient				4 Mursing H		ce 6 □Other (Spe	ecify)		
	nding Ph ath. r: Aftar th e funeral	ation:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Ti	ime of jury M	28c. Injun Worl	yat ∢? Yes 2 □No	28d. Describe hov	v injury occurred			
DIVISION	To the Hospital or Attending Physician: within 24 hours elter death. To the Funeral Director: After this cartific completely illied in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, far	m, street, facto	ory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,		
	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	Medicai (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, mination and	death occurre l/or investigation	d at the tim on, in my o	ne, date and place pinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)		
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier				9c. License		29	d. Date signed (Mon			
)	1						D 2			05-23	- 06		
	0		30. Name and address of person who 7505 OS LLY OY	completed cause of death	(Item 23a) (tertine.	Mon		21200				
	Sta Registr		31. Date filed (Month, Day, Year)	32. Flegistrar's S	Signature	hosele							

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Euna E. Osbourne	State of Marylar	nd / Department of He Certificate of De			2006 1601			
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	Osbouri		Reg. No. 2. Date of Death Month Day	3. Time of Death			
Medical Examiner	Euna 4a. Facility Name (if not institution, give street and num		ty, Town, or Location of Deat	May 14, 2006	1723 hrs			
	5818 Royal Oak Avenue	·	oodlawn		nore County			
Funeral Director	07.4.07.5633	- ' ' 1	Under 1 Year If Under 24Hr onths Days Hours Mir		YYY) 9. 8irthplace (State or Foreign			
Director	214-21-5611 1 M 2 XF Usual Residence of Decedent	48 Yrs.		0-19-37	Country)Jamaica			
any	10a, State 10b. County	10c. City, Town or Location			10d. Inside City Limits			
and show	Md. Baltimore	Woodlawn			1 Yes 2X No			
the Maryland 1 or 28a-f sh tiffed at once	10e. Street and Number	10f.	Zıp Code	10g. Citizen of	What Country?			
oith the s 23a o	5818 Royal Oak Ave.	dent Ever in U.S. 13. Was Dec	21207 edent of Hispanic Origin? (S	pecify Yes or No- 14 R	ace - American Indian, 8lack,			
r death with the Maryland or items 23a or 28a-f show must be notified at once.	1 Never Married 2 Married Armed Ford		ecify Cuban, Mexican, Puerto		/hite, etc.			
ral", o	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	1 Yes	2. No specify:		fy:Black			
hours "natur Exam	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12) College (1-4)	during most of	ual Occupation (Give kind of working life. DO NOT use ret	ired)	f Business/Industry			
5-0036 led within 72 hour Hygiene. other than "natu the Medical Exan Completed	12th grade 4yrs.		ration-Accour	Dept. nting Wo	rld Bank			
5-0(illed will Hygie d other the M	17. Father's Name (First, Middle, Last)	, -		e (First, Middle, Maiden Surna	me)			
2121; ould be fill d Mental F s marked itic event, To Be	Ureal Z 19a. Informant's Name/Relationship (Type, Print)		Delor	Ces Rural Route Number, City or T	Ewers			
MD 3 d 2 shou lth and l n 27 is 1 n aumatic				Noodbridge, Va				
	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from	20b. Place of Disposition (crematory or other pla		Date 20c. Location	on - City or Town, State			
Baltimore, permit. Pages I at Department of Hee Important: If ite njury or other tr	4 Donation 5 Other Specify:	King Mem.		24-06 Rand	allstown, Md.			
Ball Permit Depart Impor injury	21. Signature of Funeral Service Licensee		and Address of Facility	Baltimore	, Md. 21202			
Physician	23a. Part I. Enter the disease, or complications that cau	1101	rch F.H. East de of dying, such as cardiac	1101 E. Nor respiratory arrest, shock, or	heart Approximate Interval			
/Medical		d Blunt Force Trauma to th	e Head		Between Onset and Death			
	or condition resulting in death) Due to (or as a c	onsequence of):						
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a coause. Enter Underlying Cause	onsequence of):						
ed nsit	(Disease or injury that initiated events resulting in death) Last Due to (or as a c	onsequence of):						
0, be executed sician and burial - transit	d.							
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be execut. After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial - trans. To Be Completed by Physician/Medical I	UNPENDED AMENDED			Leave B				
x 6876(h certificate tending phy: use as the b	23b. Was decedent pregnant in the past 12 months?	2	ath 3 Ectopic pregna		e of delivery n Day Year			
Box (e death co	1 Yes 2 No 9 V Unknown 9 Unknown	nt at time of death 5 Other (\$ n	Specify)		1,0			
Sion of Vital Records, P.O. Box 6876 Attending Physician: The law requires that the death certificate reach reach ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the cation: To Be Completed by Physician/IM	Part II. Other significant conditions contributing to c	leath but not resulting in the underly	ying cause given in Part I.	23e. Did tobacco use co	ontribute to the cause of death?			
S, P.Cuires that a signed d be deti					3 Probably 4 Unknown			
of Vital Records, ng Physician: The law require. Wher this certificate has been signeral director, page 2 should b. n: To Be Completed	<u> </u>			24a, Was an 24 autopsy performed?	 b. Were autopsy findings available prior to completion of cause of death? 			
Rec The lifeate by page				1 ✓ Yes 2 No	1 Yes 2 No			
Vital ysician: ysician: his certi director	25. Was case referred to medical examiner?	patient 2 ER/Outpatient 3	26.Place of Death (Check		6 ✔ Other: Scene			
n of V ling Phy After th funeral on: To	27. Manner of Death 28a. Date of	Injury 28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occ				
	1 Natural 5 Pending Pending Accident Investigation Page May 14, 2	006 1715 hrs	1 Yes 2 V No	Deceased assaulted				
Division ospital or Attendin hours after death nerral Director: A y filled in by the fit Certification	Suicide Could not be	of Injury - At home, farm, street, fac Single Family	tory, office building, etc.	28f. Location (Street and Nu or Town, State) 5818 Royal Oak Aven	mber or Rural Route Number, City			
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	one) 2 Medical Examiner: On the basis of			at the time, date and place, an	d due to the cause(s)			
Ž Š	29b Signature/and title of certifier		29c. License number O.C.M.E.	2.42	igned (Month, Day, Year)			
	30. Name and address of person who completed cause	of death (Item 233)	O.O.IVI.E.	May 15,	2000			
4	Susan Hogan MD. Assistant Medica		reet, Baltimore, MD 21	201				
State	El	strar's Signature						
Registra	MAY 2 3 2006	the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s						

			For State Registrar		State	of Mai	ryland /		rtment of H		and M		giene Reg. No.2	006	16216
	Physici /Medio		1. Decedent's Name (First, Sharon Obert	Middle, Las	t)						1.	2. Date of De Month	Day	2006	3. Time of Death 2:10 P M,
	Examir		4a. Facility Name (If not ins BATTIMOZE U	lashine	ston Me	edica	al Cen	ter	4b. City, Town, o	Burn	ie_		ANN		undel
	Funeral Director		5. Social Security Number 216-48-9302 Usual Residence of Decede		ox □ M 2 □ E ▼ X X	7. Age	(In yrs. last i	Yrs.	Months Days	If Under: Hours	Min.	8. Date of Bir Septem	ber 10	9. Birth	place (State or Foreign ntry) MD
	the Maryland r28a-fehow	tor	10a. State 10b. C		del		Glen	wn or Loc							10d. Inside City Limits 1 ☐ Yes 🏋 🖫 No
\subset	th with the M 23a of 28a-f	Funeral Director	10e. Street and Number 1004 7th St						10f. Zip Code 210	60				of What Cou	ntry?
AR0	urs after death with the Maryland BI', or tterne 23a or 28a-f ehow zaminer must be notified at	چ ا	11. Marital Status 1 Never Married 25 3 Widowed 4 Div		12. Was Dec Armed F 1 Yes If Yes, G Year or I	orces? XXINo ive		If	/as Decedent of H Yes, specify Cuba ☐ Yes 21 No	an, Mexican	gin? (Spec , Puerto F	city Yes or No Rican, etc.)		Race - Ameri Black, White, pcify: Whi	etc.
21215-0	s 1 and 2 should be filed within 72 hou to 1 and 2 should be filed within 72 hou the art is marked other then "nature other treumatic event, the Madical solutions."	Completed	15. De (Specify only Elementary/Secondary (0		de completed,	(1-4or 5+)		(Give I life. D	ent's Usual Occup ind of work done O NOT use retired nemaker	ation during most	t of workin	g		f Business/Ir Home	ndustry
Q ☐ ✓	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Itam 27 is marked other then "in eny Injury or other treumatic event, the Mazit once.	To Be C	17. Father's Name (First, Middle, Last) Alwood I Hammett 18. Mother's Name (First, Middle, Maiden Sumame) Audrey E Padgett												
Mary	and 2 sho laith and h	-	19a. Informant's Name/Rel Carroll A. O			usbar		9b. Mailin 100	Address (Street 4 7th St	and Numbe , Glei	or or Rural n Bur	Route Numb	er, City or To D 210		o Code)
OB E	Pages 1 and the part: If Itan		20a. Method of Disposition ↑□\$Burial 2 □ Crema 4 □ Donation 5 □ Otl			State	ceme	tery, crem	ition (Name of atory or other place Cemeter		Da -22 - 0	16		on - City or To ttsvil	own, State
Balt	permit. Departimporti eny Injoure.		K. Gregor	1-1-	-	MOT 12	(2)		Finkofor 426 Crai	n Hwy	S, G	len Bu		MD 21	1061
	Physician /Medical		23a. Part1. Enler the disesshock, or heart failure tmmediate Cause (Final disease or condition resulting in death)	so, or control. List only o	a. Mit	aste	death. D	ES	or the mode of dying	ig, such as	/ -	respiratory a	rrest,		Approximate Interval Between Onset and Death
8760,	ate be executed by the buriel-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	}	c		consequenc	·							
Box 6	eath certific attending p for use as:	by Physician/Med	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 □ Yes 2 ☑ No 9 □ Unknown	U II.		birth 2 mant at tir	pregnancy Fetal dea		Ectopic pregnancy Other <i>(specify)</i>	,				Date of delive	ery Day Year
ds, P	fuires that n signed b	d by Pł	Part II. Other significant co	onditions co	ontributing to d	death but	not resulting	g in the un	derlying cause giv	en in Part I.			obacco use c Yes 2 □ No		he cause of death?
al Reco	: The law requii cete has been s ; page 2 should	Completed										24a. Was autor perfo 1 Yes	an 24 osy ormed? 2 No	death?	opsy findings available impletion of cause of
Division of Vital Records, P.O.	Attending Physicien: The ordeath. scroor: After this certificete by the funeral director, pag	ation; To Be		-	28a. Date (Mor	Inpatient of Injury oth, Day		Outpatient o. Time of Injury	28c. Injur Wor	er: 4 🗆 Nu	rsing Hom	(Check only only only only only only only only	dence 6 🗆		(y)
Divis		Certification;		Could not be determined	28e. Plac build	e of Injunding, etc.	y - At home, (Specify)	farm, stre	et, factory, office		2	8f. Location (: City or Tox	Street and Nu wn, State)	mber or Rura	al Route Number,
	To the Hospital or within 24 hours efte to the Funeral Dir completely filled in	Medical	29a. Certifier 12 Ce (Check only 2 Me	ertifying Phy edical Exam	iner: On the l	ne best of basis of e nner state	xamination	lge, death and/or inv	occurred at the tirestigation, in my o	ne, date and pinion, deat	d place, a	nd due to the d at the time,	cause(s) and date and plac	manner as se, and due to	stated. o the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of c	certifier d	ûw				29c. Licens		144		29d. Date sig	ned (Month,	Day, Year)
_	15		MARIA GA	VIR	completed cau	D	301	Ho:	pital-	D/ (filer	Burn	ne C	MD à	21061
	Sta Registi		31. Date filed (Month, Day,	4	106	Registrar'	s Signature	do	who						

06-03339 Please Type or Print in Black Indelible Ink Edward W. Pannell, Sr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 17, 2006 1357 hrs Edward William Pannell, Sr. **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Foreign Country) MD 212-44-1478 Months Davs Hours Min. Director 1 X M 7-28-1945 2 F Usual Residence of Decedent 'n 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Examiner must be notified at once. MD 1 Yes 2 X No Howard Hanover should be filed within 72 hours after death with the Maryland and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7510 Race Road 21076 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Yes Give Year 1 Yes 2 X No specify: 3 Widowed 4 Divarced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical is marked other than MD 21215-0036 12 Self Employed Service Printing 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Doris Pannell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Pannell/ Wife 7510 Race Road Hanover MD 21076 ges I and 2 s of Health a 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Baltimore, crematory or other place)
Loudon Park Cemetery 1 XXBurial 2 Cremation 3 Removal from State 5-22-2006 Baltimore, MD Important: injury or oth Donation 5 Other Specify 22. Name and Address of Facility Ambrose Funeral Home, Signature of Furferal Service Killensee 1328 Sulphur Spring RD. Arbutus MD 21227 that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complicatio Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical UNPENDED **AMENDED** the attending physician ed for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) To the Hospital or Attending Physician: The law requires that the death within 24 hours after death 1 Yes 2 No 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page Yes 2 🗸 No Yes 2 No 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Nursing Home 5 Residence 6 Other DOA After this 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No Pending Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 18, 2006 bX Name and address of person who complete c use of death (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Morfit Day, Year) State

Registra

			1 - For State Registrar		-	Departmer Certifica		lealth and fi Death		Reg.	ne No20	16	15218
Н	Physici	an	Decedent's Name (First, Middle,	Last)					2. Date of Month		Day	Year	3. Time of Death
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	Examir	ier,	4a. Facility Name (If not institution,)	4b. City	, Town, c	or Location of Death	1		4c. County of	of Death	
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	ylanc		10a. Stale 10b. County		10c. City, Town	n or Location						1	Od. Inside City Limits
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	d within 72 hours after death with the Maryland Jiene. I then "natural", or Items 23a or 28a-f show The Mscical Exemirer must be notified at	Director	10e. Street and Number			10f. Zi	p Code			10g.	Citizen of W	hat Coun	try?
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	Items	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Dece	dent of F	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or	No-		- America , White, e	an Indian,
36	or It		1 Never Married 2 Married	d 1 ☐ Yes 2 ☐ If Yes, Give X		1 ☐ Yes					Specify:	, *************************************	B.C.
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Maryland	Q 12 40 @	To Be	BENJAMIN	BRYANT				ZUI	LLA	MA	E F	ENNE	Г.Г.
N.	2 should be and Mental Is marked e	-	19a. Informant's Name/Relationship	(Type, Print)	19b.	. Mailing Addres	s (Street	and Number or Rui					
Š	₽ £ > ₽		THOMAS RICHARDS	ON-HUSBAND				RIVE APT.					21209
ē,	s 1 and 2 f Health item 27		20a. Method of Disposition		20b. Place of	Disposition (Na y, crematory or	me of		Date		Location - C		
Ē	Page ent o nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			SON FOR		, , , , , , , , , , , , , , , , , , ,	/16/06	5 (OWINGS	MTT.1	LS MD
altimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		21. Sgruture of Funeral Service Lin	~	^						RAL HO		
ä	Depa Impo eny ii		No. B.	Visit		4300	WABA	SH AVE.,				212	
			23a. Part 1. Enter the disease, or co shock, or heart failure. List or	omplications that cause	d the death. Do n								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition										Onset and Death
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Ľ,	Examiner		Convention line and distance	DIABE	TES MELL	ITUS II							
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Ö,	e exe		resulting in death) Last	Due to (or as	a consequence of	of):							
8760,	death certificate be executed e attending physicien and ad for use as the burial-transit	licat		d								-	
9	that the death certificated by the attending placed for use as t	Physician/Med	IF FEMALE:	20 1									
Вох	ath c	an	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic p		•			23d. Date Mont		ry Day Year
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of death	5 Other (s	oecify)			-	l l l l l l l l l l l l l l l l l l l		Day Tou.
P.O.	law requires that the as been signed by th 2 should be detache	P.	Part II. Other significant conditions	s contributing to death b	ut not resulting in	the underlying	Talled div	en in Part I	23e Di	d Johace	O USB contrib	uto to the	e cause of death?
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3ec	has has	Completed							24a. W	topsy	pri	or to com	sy findings available pletion of cause of
Division of Vital Records,	n: The icate hi r, page		200						1 ☐ Yes	rformed 2	No 1	ath?] Yes :	2□ No
Ξ	Attending Physician: r death. ector: After this certifics by the funeral director, g	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Deat					
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o	ding h. After fune	fion	1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) In	njury M	28c. Injun Worl	k? Yes 2 □ No	280. Describ	e now ir	njury occurred	1	
2	Attendi death. ctor: A y the fi	fica	3 ☐ Suicide 6 ☐ Could not	be 290 Place of Ini	ury - At home, far			163 2 110	281. Location	(Street	and Number	or Pural	Route Number,
<u>S</u>	lor A after Dire	Certification;	4 Homicide determine	building, el	c. (Specify)	m, street, ractor	y, once		City or 7	own, St	ate)	or nurar	HOULE NUMBER,
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	withir To th	Ž	29b. Signature and title of certifier			290	c. License	e number		29d. l	Date signed (Month, D	Day, Year)
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	7		30. Name and address of person wh	o completed cause of d	leath (Item 23a)	ype, Print)	1 1	1	1	0		1	
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п	Physici		/	KADFURD				Month	Day 18	Poar 2006	7:30 AM
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or I	ocation of Death	11119		ty of Death	
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	Funeral		5. Social Security Number 6. Sec.	7. Age (In yrs.	last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	Birthp Coun	lace (State or Foreign
	Director		097-26-0191	M 2 3 F	2 Yrs.			7/27	11933	LEN!	USYLVANIA
	and *		Usual Residence of Decedent 10a, State 10b, County	10c. Cit	y, Town or Le	ocation				1	0d. Inside City Limits
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	288	Director	10e. Street and Number	0,0	101 171	10f. Zip Code		1	0g. Citizen o	f What Coun	itry?
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	deat	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe	ecify Yes or No-	14. R	ace - Americ	
9	after or its	/Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:	,	Spec		010.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ahow ta Medical Exemirer must be rotified at	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:	1.40					WH	
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ORIGINAL

Sheila RAdFord

			T – For State Registrar	State of Marylar		ent of Hea			iene	006	16220
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	Funeral Director		5. Social Security Number 6. Se 216 - 34 - 9015	E MEDICAL (x 7. Age (In yrs.	last birthday) If Un Mont		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, APRIL S	Year)	Cour	lace (State or Foreign
7	death with the Maryland rms 23e or 28e-f show	ral Director	10a. State 10b. County MD HARFOL 10e. Street and Number 2002 GALWAY		Ity, Town or Location RES'T H 10f.	ILL Zip Code 21050)	11	_	of What Cour	0d. Inside City Limits 1 ☐ Yes 2 ☐ NO http?
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AC Balt	permit. Departm Importa eny inju		21. Signature of Fuyeral Service Licens 107 - 107 - 108 23a. Part1. Enter the disease, or complete	M.	22. Name	and Address o	Facility RAC CHU	APEC - B		NEW PORE	ST H.II M.D. Approximate
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Divis	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	al Certification;	3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier 1 Certifying Phys	28e. Place of Injury - At h building, etc. (Special sician: To the best of my known to the street of my known to the street of my known to the street of my known to the street of my known to the street of my known to the street of my known to the street of my known to the street of my known to the street of my known to the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the	(y)	ed at the time of	tate and place a	28f. Location (Str. City or Town,	State)	mannor as at	atod
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	Sta Registr		A Kowa World M 31. Date filed (Month, Day, Year)	propleted cause of death (Item 7 602 760 32. Registrar's Signa 2006	HIPUR	SACTI	201),	2127	5-2: 6	4.06	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? [] [] [1 - For Stete Registrar Certificate of Death 2 Date of Death s Name (First. A 3. Time of Death Day 4 14 M Year 12 ZOO6 4c. County of Death 4b. City. Town, or Location of Death BALTIMORE
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 XM 2 ☐ F 212-12-7961 02/08/1920 86 VA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 902 N. ALLENDALE ST. USA 21229 12. Was Decedent Ever in U.S. Armed Forces? 1 1274'es 2 □ No If ¥8s, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 13 YEARS SUPERVISION STEEL INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIE RIDDICK ALICE PETTIWAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 N. ALLENDALE ST., BALTIMORE, MD CLEO RIDDICK/WIFE 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) GARRISON FOREST 05/22/2006OWINGS MILLS, MD 21. Signature of Fune/al Service Licensee 22. Name and Address of FacilityWESLEY CHAVIS, JR. FNRL. HM. es 2007 EASTERN AVE., BALTIMORE, MD 23a. Part1. Enter the diseas , or complications if shock, or heart fail to List only one cause death. Do not enter the mode of dying, such as cardiac ar respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): monit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 7,

Physician /Medical Examiner certificate be executed

permit. Pages 1 end 2 Department of Health a Important: if Item 27 is any injury or other trau once.

Physician

/Medical

Examiner

Director

Funera

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Completed

Be 2

Funeral

Director

is 1 end 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other then "natural", or iteme 23e or 28e-f show other traumatic event, it a Medical Exaction invalue to notified.

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

4a. Fecilit

MD

Examine rate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit Physician/Medical Completed by this certificate Hospital or Attending Physician: After this certification, funeral director, Be Certification; To within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

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Part II. Other significant cond	itions contributing to death but	t not resulting in the und	derlying cause given in Part I.
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right local	w Cereptol	VIDOUIHY	INFARction
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25. Was case reference examiner?	red to medical	26. Place of Death (Check only one)										
1 ☐ Yes 2-	No	Hospital: 1 Impatient 2	ER/Outpatient	3 🗆 (DOA Other: 4 Nursing H	flome 5 ☐ Residence 6 ☐ Other (Specify)						
27. Manner of Death 1 Death 2 Accident	5 Pending investigation		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred						
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		nome, farm, stree	et, facto	ory, office	281. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier	1 Certifying Ph	lysician: To the best of my kn	owledge, death	occurre	ed at the time, date and place	and due to the cause(s) and manner as stated						

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if	ring Physician: To the best of my knowledge, death occurred at the time, date and place	a and dup to the squar(s) and manner as at-td
	the time, date and place	s, and due to the cause(s) and manner as stated.
IC	al Examiner: On the basis of examination and/or investigation, in my opinion, death occur	urred at the time, date and place, and due to the cause(s)
	and manner stated	, and and a decide (c)

29b. Signature and title of certifier	_
$M \cap M \cap M \cap M$	20
H. Head No.	200
20. Name and address of pare while admile	

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day)

Registrar

Medical

(Check only one)



			1 - For State Registrar	State of Marylan		artment of H <i>rtificate of L</i>			giene	06	16222
	Physici	an.	Decedent's Name (First, Middle, Last)	1 0-1	20			2. Date of Dea		Year	3. Time of Death
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\$ 100 mg	Funeral Director		217-40-0497	7. Age (In yrs. 60	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 08/20	, Year) 1/1945	9. Birthpla Countr MD	ace (State or Foreign ry)
	land MC		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	ocation				10	d. Inside City Limits
	Mary	tor	MD	BAI	LTIMO	RE					1 XYes 2 □ No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Countr	ry?
	ath w		1115 WALKER AVE.			21239			USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If itsm 27 is marked other then "natural", or items 23s or 28s-1 show any injury or other traumatic svent, it a Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U. Armed Forces? 1 [XYes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☎No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	ecfy Yes or No- Rican, etc.)	Blaci	e - America k, White, et : BLA	tc.
9	2 hou	ted	15. Decedent's Educati	ion	16a. Dece	dent's Usual Occupa	tion		16b. Kind of Bu		
21215-0036	d within 7 giene. or then "r	Completed	(Specify only highest grade of Elementary/Secondary (0-12) 12th	College (1-4or 5+)	life.	kind of work done di DO NOT use retired) PENTER	uring most of workii	ng	CONST	RUCT	TON
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Ĕ	Page ment c ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	Oval Irom State		N FORES	· 1	/2006	OWINGS	MIL	LS. MD
Baltimore,	permit. Pages 1 a Department of Her Important: If Itsm sny injury or othe		21. Signature of Fune Service Ricensee	Such	22	Name and Address	of FacilityWES	LEY CH	AVIS,	JR. I	FH 21231
S. 4		8	23a. Part1. Enter the disease, or complication shock, or heart failure. (is only one of	ions that caused he death ause on each he.	Do not ent	er the mode of dying	, such as cardiac o	r respiratory arr	est,	A	Approximate nterval Between
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	7		30. Name and address of person who comple	MD 3900 L	SCH/	Print) PAVEN BA			ORE N	10 2	21218
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2, 3, 2006	32. Registrar's Signatu	ure	1					
597		100	MAI & & LUUU 3	ALL WASHINGTON	6						

			1 - For State Registrar	State of	Maryla	nd / Dep <i>Ce</i>	artmen rtificate	t of H e of L	ealth a Death	and M	lental Hy	giene (006	162	23
	Physic /Medi		1. Decedent's Name (First, Middle, Prentis		ichard	son					2. Date of De Month May	ath Day	2006	3. Time of E	
	Examir		4a. Facility Name (If not institution, Southern Maryla	and Hospi			4b. City,	Town, or Clir	Location o	of Death			nty of Death nce Ge	orge's	
	Funeral Director		5. Social Security Number 571-70-5242 Usual Residence of Decedent	5. Sex 1 [X] M 2 □ F	7. Age (In yrs 5	. last birthday, 9 Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Bin (Month, Da Oct • 3	h y, Year) , 1946	Coun	lace (State or i try) fornia	Foreign
	Maryland a-f ehow	tor	10a. State 10b. County	e George'	I	ity, Town or L	ocation	Clir	iton				1	0d. Inside City	~~
	th with the 23a or 28a	al Director	10e. Street and Number 9211 Stuart Lar	ne			10f. Zip		0735			10g. Citizen o Unite	of What Coun	,	
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene, is marked other than "natural; or iteme 23a or 28a-f ehow aumatic event, the Medical Examinational Legicality at	by Funeral	11. Marital Status (Unknowi 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Amed For	ces?Unkn 2□No e	J.S. 13. own	Was Deced if Yes, spec	ify Cubar	n. Mexican	. Puerto	ecify Yes or No Rican, etc.) nown)		lace - Americ lack, White, c		
Maryland 21215-0036	i within 72 ho iene. r then "netu ine Medicel	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) (Unknown)	Education grade completed) College (1- (Unknown	4or 5+)	(Give	dent's Usua kind of wor DO NOT us nknown	k done di e retired)	tion uring most	t of worki	ng	16b. Kind of	Business/ind	lustry	
yland ;	should be filed and Mental Hyg marked other umatic event,	To Be C	17. Father's Name (First, Middle, La (Unknown)	ist)					(Unkı	nown		Maiden Sum	ame)		
ore, Mar	permit. Pages 1 and 2 should by Department of Heelth and Menta Important: If item 27 is marked eny injury or other traumatic av 200ce.		19a. Informant's Name/Relationship She1by G. Hamilt 20a. Method of Disposition 1□Burial 2 MiCremation 3	on / Gua	20b.		Barri	ngto	n Ct	. , M:	IRoute Numbe itchell ate	ville,		0721	
Baltimore,	permit. Pag Department Important: i eny injury o		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Like	cify)	Mou38	esapeal	ke Cre	emato d Address	ry 5	d Cre	/06 emation er Spri	Servi	ville,	MD	
	Physician /Medical Examiner	mlner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Satus title list could be a fany, leading to immediate cause. Enter Underlying Cause (Disease or injury)	omplications that cally one cause on each a	used the dea	th. Do not end	er the mode	of dying	, such as o	cardiac o	r respiratory ar	rest,	20,10	Approximate Interval Betwe Onset and De	
Box 68/60,	the death certificate be executed by the attending physicien and ched for use as the burial-transit	Physician/Medical Examin	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	th 2 Feta	ancy	Ectopic pre						Date of deliver	y Day Yea	ar
T	that the dended by the solution		1 Yes 2 No 9 Unknown Part II. Other significant conditions	9□ Unknov			Other (spe		in Part I		23e. Did to			cause of deal	
ecords,	requires	eted by									1 🗆 Y	es 2 □ No	3 🗌 Proba	bly 4.⊠Ünk	nown
י ד	ine la ate has page 2	e Completed	25. Was case referred to medical						OC Diago	-101		med?	death?	sy findings ava pletion of caus No	ulable se of
<u> </u>	rnystcien: r this certific ral director,	To B	examiner? 1 ☐ Yes 2√ No	Hospital: 1. 1 In	patient 2	ER/Outpatien	t 3□ DOA	Othor			Check only or	-	ther (Specify)		_
ion of	ath. or: After th		27. Manner of Death 1.☑Natural 5 ☐ Pending 2 ☐ Accident investigat			28b. Time of Injury		c. Injury a		2	8d. Describe h				
DIVISION	ref or Att	Certification;	3 Suicide 6 Could not determine	ed 286. Place of building	g, etc. (Specif						8f. Location (Se City or Town	n, State)			:
:	one nospire or accending Prysicient: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Medical	one) 2 Medical Ex	Physician: To the baseminer: On the baseminer and manner	sis of examina	wledge, death tion and/or inv	estigation, i	in my opii	nion, death	piace, ai	d at the time, d	ate and place	, and due to t	he cause(s)	
1	o T ¥it		1 0.	m.0				Dy		5	1	9d. Date sign			
	,) ,		30. Name and address of person when Michael Sida Ro 31. Date filed (Month, Day, Year)	o completed cause	of death (Iten	n 23a) (Type,	Print) 95tan	N	41	1 4	FWASH	yt on	MA	2076	8
E	Sta Registr			77	yısındı ə ƏlYNƏ	M. O.	NA B					*			

		1		artment of Health and Mertificate of Death		iene2 0 0 6	15224
		-47	Decedent's Name (First, Middle, Last)		2. Date of Deat Month		3. Time of Death
	Physicia		James Leo Riley, Jr.		May 22	, 2006	8:15am м
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	-		Continuum Care	Sykesville		Carroll	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Dec. I	Year) 9. Birth	place (State or Foreign intry) MD
٠,	Director		216-34-0099 A		Dec. I	0,1930	TID
	/land		10a. State 10b. County 10c. City, Town or I				10d. Inside City Limits
	Man Ba-f sh	tor	MD Carrol1	Sykesville			1 ☐ Yes 2X No
	or 28)ire	10e. Street and Number	10f. Zip Code	11	0g. Citizen of What Cou	intry?
	ath wi	ral	6311 Georgetown Boulevard Apt. D	21784	7 7	USA 14. Race - Amer	Soon Indian
	er de	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	Black, White	
36	rs afte	by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 1 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☐XNo Specify:		Specify: Wh	nite
8	72 hours after death with the Maryland Inaturet; or Items 23e or 28e-f show Visal Exactinat must be notified at	ted		edent's Usual Occupation		16b. Kind of Business/l	ndustry
215	hin 7.	Completed	(Specify only highest grade completed) (Giv life. Secondary (0-12) College (1-4or 5+)	e kind of work done during most of workii DO NOT use retired)	ng		
21	e filed within al Hygiene. I other then " vent, I're Mo	Con	11	Machine Operator		Factory	
nd		Be	17. Father's Name (First, Middle, Last)	18. Mother's Name			
<u> </u>	2 should be a nand Mental I is marked o raumatic eve	^L	James L. Riley, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Ma.	LISTE ling Address (Street and Number or Rura	Dansrea		in Codel 21707
Ma	d 2 tra			l Georgetown Boulev			
6	Health tem 27 other tr		20a. Method of Disposition 20b. Place of Dis	position (Name of permatory or other place)	ate	20c. Location - City or	Town, State
OL	Pages ent of ht: If i			ty Cremation 5/23/	2006	Sykesville	e, MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Heall Importent: If item 2 eny injury or other 2005.			TAIGHT FUNERAC ^{ility} HOME Sykesville, MD 2178	& CHAP	EL(box 195) -795-1400	
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause or each line.				Approximate Interval Between
	Prysician		Immediate Cause (Final	2 Delenema	-2		Onset and Death
	/Medical		disease or condition resulting in death) a Due to (or as a consequence of):	1 Dellancaca	1		
	Examiner		Sequentially list conditions b. Metaglatic	- resions +	0 117	er	
7	od sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
V	and and I-trans	Examine	Cause (Disease or injury that initiated events c				
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit						
687	ficate by physical transfer the b	Physician/Medical	d				
Вох	leath certifica attending ph	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	□Ectopic pregnancy		23d. Date of deli	*
	death	sicia	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
P.O	at the de by the stached	Phys	9 Unknown	and the second in Cont.	230 Did to	bacco use contribute to	the cause of death?
	res that signed to be det	by	Part II. Other significant conditions contributing to death but not resulting in the	unuenying cause given in rain.	1 🗆 Ye		bably 4 Unknown
oro	w require been sig	eted	Carl at the Es	- le 1	24a. Was a	n 24h Wara au	topsy findings available
3ec	has the 2 s	Completed	CC145024000 1005		autops perforr	sy prior to death?	ompletion of cause of
a		e Co	25. Was case referred to medical	26. Place of Death			2 No
of Vital Records,	Physicien: this certific ral director,	0 B	examiner? 1 Yes 2 No	Other +		ence 6 Other (Spec	cify)
		H	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe ho	ow injury occurred	
Ö	Attending I ir death. ector: After by the funer	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	l or Attence after death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Si City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To the Ho within 24 h To the Fu completely	Me	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Month	n, Day, Year)
	•		Melet Blesonsom)(475	5	21991	00
	3		30. Name and address of person who completed cause of death (Item 23a) (Typ	(121 Fe 300)	11,10	evelle	(M).
ok.	St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 2 3 2006	perke			

			1 - For State Registrar	State of Ma	aryland /	Depa		t of H	eaith a		ental Hy	giene Reg. No.	005	16225
	Physicia	an	1. Decedent's Name (First, Middle, Last) Willard Ruby Sr.								2. Date of De Month 1		2006 ^{Year}	3. Time of Death 7:16am M
140° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (110° (/Medic Examin	al	4a. Facility Name (If not institution, give st 507 Church Street	reet and number)				Town, or Wind	Location o	f Death	riay I	4c. C	county of Death	
	Funeral Director		E1E 34 0743	M 2□F 7. Age 71	(In yrs. last b	virthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Nov 5	1934	9. Birth Cou	place (State or Foreign intry)
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Carrol1		10c. City, To New W									10d. Inside City Limits 1 Yes 2 □ No
	h with the 23a or 28	Funeral Director	10e. Street and Number 507 Church Street				10f. Zip 21	Code 1776				10g. Citize USA	en of What Cou	untry?
900	be filed within 72 hours after death with the Maryland tall Hygiene. do other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, I're Medical Examinar must be notified at	ρĺ	11. Marital Status 1: 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent B Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Was Deced f Yes, spec l ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify: Wh	, etc.
Maryland 21215-0036	han a	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5		(Give life. L	dent's Usua kind of wor DO NOT us inter	rk done d se retired,	urina most	of workir	ng		improve	
yland 2	12 should be filed withir h and Mental Hygiene. 7 is marked other than freumatic event, Ira M	To Be C	17. Father's Name (First, Middle, Last) John Ruby Sr.						Matt	ie Al				
	ss 1 and 2 should of Health and Men item 27 is marke r other treumatic		Wayne Ruby (son)	e, Print)	3	711	Fring	ger F		laney	town,	Md 21		,
Baltimore,	permit. Pages 1 Department of He Important: If Iten any injury or oth		20a. Method of Disposition 1	moval from State	Good Place	Shep	herd	Cem.		5-22-		Ellic	ation - City or T Cott Cit	ty, Md
Balt	permit. Page Department o Important: If any injury or 9005.		21. Signature of Funeral Service License	cej O							tht Fun		Home &	Chapel
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each lin	the death. Do		er the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death Paris
7,092	s be executed sician and s burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence									
P.O. Box 68	The law requires that the death centificate be executed ate has been signed by the attending physician and begge 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pr Other (sp					23	3d. Date of delin Month	very Day Year
	requires that been signed b should be deta	6	Part II. Other significant conditions cont	ributing to death b	ut not resulting	in the u	nderlying c	ause give	en in Part I.			obacco us Yes 2 🗆		the cause of death?
i Records,		Completed								_	24a. Was auto perfo		prior to co death?	lopsy findings available ompletion of cause of
Vital	Physician: Th r this certificate ral director, peç	Be	25. Was case referred to medical example?	ospital:				Othe	200		(Check only			
of	ng Phys Iter this Ineral di	ition: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 🗀 Inpatie 28a. Date of Inju (Month, Day	ry 28b	Time of Injury		8c. Injury Work	4 140	2	ne 5 Resi		Other (Specoccurred	ify)
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc.		larm, str	eet, factory	, office		2	28f. Location (City or To	Street and wn, State)	Number or Rui	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in I	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin		examination a									
	To the within To the comp	ž	29b. Signature and title of certifier				290	License	number			29d. Date	signed (Month	Dey, Year)
	Δ		30. Name and address of person who gor	mpleted cause of d	eath (Item 23a	a) (Type.	Print)	1500	924	1 .		War	14,20	10 b
	9		Hewart P. Hend 31. Date liled (Month, Day, Year)	U50151-1	M) 39 ar's Signature	73	Mana	chast	4/ 20	W	lanche	34 45	mU	2110/
, 45	Sta Regist		MAV 9 3 200	1	a. 3 Signature	1	made 3							

ORIGINAL

			1 - For State Registrer	State	of Marylan		rtment tificate					Reg. No.	006	16226
	Physicia	an	1. Decedent's Name (First, Midd	le, Last)							2. Date of De Month	Day	Year	3. Time of Death
	/Medic			Marie		Riley					May	17	2006	11:45 P ^M
*	Examin	er	4a. Facility Name (If not institution		um <i>ber)</i>				Location	of Death			inty of Death	
			1623 Loriner				Glen			2411			e Arui	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ XF	7. Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, De June 22	th ly, Year)	9. Birth	place (State or Foreign intry)
	Director		219-98-5984 Usual Residence of Decedent		39	113.					June 22	, 1900	MID	
	and and		10a. State 10b. County	,	10c. City	y, Town or Lo	cation							10d. Inside City Limits
	Many f aho	៦	MD Anne	Arundel	0	Glen Bu	rnie							1 ☐ Yes 2 🖺 No
	28. 28.	Funeral Director	10e. Street and Number		1		10f. Zip	Code			T	10g. Citizen	of What Cou	intry?
	Sa or	□	1692 Towinse Dd				2106	. 1				USA		
	Jeath me 2;	era	1623 Loriner Rd	12. Was De	cedent Ever in U.	S. 13. V			spanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)		Race - Ameri	ican Indian,
0	r Rer	F	1 ☑Never Married 2 ☐ Mar	ried 1 ☐ Yes	2 → No						Rican, etc.)	E	Black, White	, etc.
3	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, C Year or	Sive 11 Dates:	1	∏Yes 2	2∐ No	Specify:			Spe	city: Wl	hite
ב כ	filed within 72 hours after death with the Maryland Hybiene. ther than "natural", or Items 23s or 28s-f show the true Madical Examiner must be notified at	Completed		nt's Education	√)	16a. Deced	lent's Usua	f Occupa	ition	t of worki	in a	16b. Kind o	f Business/Ir	ndustry
V	e.	ם	Elementary/Secondary (0-12)	Ť	(1-4or 5+)	life. L	kind of wor DO NOT us	e retired))		9			
7	or th	ő	9			Cook							arauni	t
	d oth	Be	17. Father's Name (First, Middle,	Last)							(First, Middle		name)	
<u>8</u>	should be nd Mental n marked o	၉	Leon P. Riley						Wan	da L	. Spend	e		
2	C/ 00 = 0		19a. Informant's Name/Relation:	10							al Route Numb			p Code)
2 5	and lealth m 27		Mr. Leon P. Ri	ley/Fathe					₹d.;G		Burnie,			
ב ס	ges 1 au t of Hea if item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 Removal from	Ciata	lace of Dispo- emetery, crem	natory or ot	her place) M		9,2006		on - City or T LSV 1116	
	tant:		4 Donation 5 Other (S		Che	sapeak Cer	te cre	matı	LOII					
Dallimo	permit. Pages Department of I Important: If its any Injury or of		21. Signature of Fune/al Service	Licensos	M01411	22	. Name and	d Addres	s of Facilit		I S ome Gle	second n Burn		
			23a. Part I. Enter the disease, o shock, or heart failure. Lis	r complications that	caused the death	h. Do not ente	er the mode	of dying	, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between
, (Physician		Immediate Cause (Final	2	~0	1-	Can	100	0~					Onset and Death
£	/Medical		disease or condition resulting in death)	a Due t	o (or as a conseq	uence of):		- (0						7 10/00-10-
	Examiner													
7		ner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	o (or as a conseq	uence of):								
	cuted nd ransi	Examiner	that initiated events) c										
ĵ	be executed ician and burial-transit	EX	resulting in death) Last	Due to	o (or as a conseq	uence of):								
200	ate he	cal		d										
ĕ	certificate nding phys ise as the	Ved	IF FEMALE:											
Š	wrequires thet the death certifics been signed by the attending ph should be detached for use as t	Physician/Med	23b. Was decedent pregnant		utcome of pregna birth 2 Feta		Ectopic pre	gnancy					Date of deliv	
	e death he atten	SICI	in the past 12 months?	4□Pre 9□ Unk	gnant at time of de nown	eath 5□	Other (spe	ecify)					Month	Day Year
	law requires thet the as been signed by the 2 should be detached.	P.	9 Unknown								00. 5:4.			
ń	igner igner	þ	Part II. Other significant condition	ons contributing to	death but not res	ulting in the ur	nderlying ca	tuse give	n in Part I.	•		~		the cause of death?
coras,	Ben s	ted									1 🗆	Yes 2 No	3 L Pro	bably 4 Unknown
Ŭ	las b	p de									24a. Was	psy	prior to co	opsy findings available ompletion of cause of
ב	The page	Completed									perfo	rmed? 212 No	death?	2□ No
119	clan: ertific	Be	25. Was case referred to medical examiner?							of Death	(Check only o	one)		
5	thysis this c	၉	1 ☐ Yes 2 No			ER/Outpatien			4 L NU		me 5 Resi			fy)
	ing P	9	27. Manner of Death 1 Manual 5 ☐ Pendi	/4.4-	e of Injury onth, Day Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe	how injury occ	curred	
20	tend leath tor: /	cat	2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Could	not be			М		'es 2 □					
DIVISION	or At	Certification:		nined 286. Pla	ce of Injury - At ho ding, etc. (Specify	ome, farm, stre v)	et, factory,	, office			City or To	Street and Nu wn, State)	mber or Run	al Route Number,
	pital ours e aral (20a Cartifica And Carata :	na Ohyaisia - : T	he heat of one to	wlodes deed		nd Abr = 11	a al=4.	el ele:	and dist.			
	To the Hospital or Attending Physician: The law within 24 hours elter death. Within 24 hours elter death. Within 24 hours all Director: Attenthis centificate has a completely filled in by the funeral director, page 2 s	edical	29a. Certifier 1 Certifyi (Check only 2 Medical one)	ng Physicien: To to Examiner: On the and ma	he best of my kno basis of examina inner stated.									stated. to the cause(s)
	vithin o the	Me	29b. Signature and title of certific				29c.	License	number		Lan (3)	29d. Date sig	ned (Month,	Day, Year)
	- 5 - 0		MARA	han.	- M.D	>		D3	950	25		May	i8 "	2006
	1.		30. Name and address of person	who completed ca	use of death (Item	1 23a) (Type	Print)	1		1	1	9	10/	10
	ψ		Yndhish	Mark		5 HO	spila	10	rive	CA	can Isi	imil	7	21061
	Sta	te	31. Date filed (Month, Day, Year) 32.	Régistrar's Signa	ture	OLDE S	,						
	Registr	ar	MAY 2	3 2006 x	Parago s	De della	S. Carlo							
						-								

		4	For State Registrar	State of Maryla		irtment of H tificate of L			giene 2 0 0 6	5 16227
			Decedent's Name (First, Middle, Last) _	\sim			2. Date of Dea	ath Day Year	3. Time of Death
	Physicia /Medic		EDWARD	13	KASII	USKI		MAY	16 200	
	Examin		4a. Facility Name (If not institution, give	street and number) ASH (AGTOK)	MED	4b. City, Town, or	Location of Death		4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Se		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da May 17,	v. Year) C	thplace (State or Foreign ountry)
7			Usual Residence of Decedent 10a State 10b, County	100 (City, Town or Lo	nation				10d. Inside City Limits
2	show show	ا ج								1 ☐ Yes 2 🖾 No
N of	28a-1	Director	MD Anne Aru 10e. Street and Number	ndel	Glen Bu	10f, Zip Code			10g. Citizen of What C	ountry?
4	a or	ā	314 Maryland Aven	ue		21060			U.S.A.	
400	ms 2:	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No		
d 21215-0036	2 should be seen within 72 hours eiter death with the waysa. and Mental Hygiene. and Mental Hygiene. is marked other then "natural", or items 23s or 28s-1 show sumstic event, the Madical Examinar must be notified at	by Fur	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:	1	Tes, specify cuba I ☐ Yes 2 ☑ No	Specify:	o rican, etc./	25000	white
Maryland 21215-0036	oatura Cal	ted	15. Decedent's Edu (Specify only highest grad	reation	16a. Deced	lent's Usual Occupa	ation	kina	16b. Kind of Business	/Industry
2	9 9	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired	1)	Ü	Longshore	
2	Hygier Hygier Sther th	ပိ	17. Father's Name (First, Middle, Last)		Long	gshoreman		ne (First Middle	Associati Maiden Surmame)	on
anc	e d ia	Be c	Hipolite Rasinski					ia (unkr		
aryla E	and Me	2	19a. Informant's Name/Relationship (T		19b. Mailin	g Address (Street			er, City or Town, State,	Zip Code)
	s I and 2 should if Heelth and Men item 27 is marks other traumatic		Mr. Walter Rasins	ki / nephew	924	Calvert .	Avenue;	Saint Mi	chaels, MD	21663
.	of Heelth fitem 27 rother tr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	1	Place of Dispo	sition (Name of natory or other place	(e) May	Date 20,	20c. Location - City or	r Town, State
Ĕ .	rages ment of I ant: If its ury or o		4 Donation 5 Other (Specify,			ary Cemet	ery 2000	6	Dundalk,	
Baltimore,	permit. Pages Department of important: If ii eny injury or o		21. Signature of Funeral Service Licens	///	22			_	n Funeral H Irnie, MD 2	
			23a. Part1. Poter the disease, or comp shock, or heart failure. List only of	lications that caused the de	ath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	CORONA	151	ARTER	y Dise	PASE		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	ARTER	+ 18	Trus	\supset	
П	*	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse		1/2001	105	Type		
V	d d anslt	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.				•		
oʻ	icate be executed physicien and s the burial-transit	Exa	resulting in death) Last	Due to (or as a conse	equence of):					
8760,	ate be hysici the bu	dicai	(d						
	ding p	Mec	IF FEMALE:	23c. If yes, outcome of preg	nancy				22d Data of da	di can
Вох	thet the death certified by the attending detached for use as	Physician/Me	in the past 12 months?	1 Live birth 2 ☐ Fe	etal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	Day Year
P.O.	the d	nysic	1 Yes 2 No 9 Unknown	9 Unknown						
ري ص	The law requires thei the death certificate has been signed by the attending page 2 should be detached for use as	by Pi	Part II. Other significant conditions of			nderlying cause giv			obacco use contribute t	to the cause of death?
ğ	w require been sig should b	ted	CHRONIC UB.	STRUCTIUS	E 100	-MONAI	ZYLVISE	ASE IN	Yes 2 No 3 F	robably 4 Unknown
ecc	e law r has be je 2 sh	Completed						24a. Was autoj	prior to	utopsy findings available completion of cause of
<u> </u>	cete h	Con						1 Yes	ormed? death? 2☐ No 1☐ Ye	
Š.	sectifi rector	Be	25. Was case referred to medical examiner?	Hospital:	¥-a-a	oth Oth	26. Place of Dea			
ō i	Phys rthis araldi	1: To	1 ☐ Yes 2 No 27. Manger of Death	28a. Date of Injury	ER/Outpatier 28b. Time of	28c. Injur	y at		dence 6 Other (Spi how injury occurred	өспу)
ion :	tanding eath. tor: Afte the fune	ation	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1	k? Yes 2 ☐ No			
Division of Vital Records,	i or Atta after de: Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe		eet, factory, office		28f. Location (City or To	Street and Number or F wn, State)	Rural Route Number,
	To the Hospital or Atlanding Physicien: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C		ysician: To the best of my k niner: On the basis of exami and manner stated.						
:	ithin (o the	Med	ook Signature and title of partition	1/		29c. Licens	e number		29d. Date signed (Mor	ith, Day, Year)
	⊬ ≯ ⊬ ŏ		1 Rieland	E/ /MI	>	Do	2719		MAY 17	2006
	1/1		30. Name and address of person who	completed cause of death (II	tem 23a) (Type,	Print)	,	Λ	8	11.
	10		RICHARDE	FISHEIZ	4710	FENNIN	GTON	3041	DALTIMO	ORE MD.
	St Regist	ate	30. Name and address of person who a Sic CHAV2 DE 31. Date filed (Month, Day, Year)	22. Registrar's Sig	nature /	de				

denick C. Keese

		Please Typ St					. Ensure A lealth and	-		_	
		1 - For State Registrar			Cer	tificate of	Death		Reg. No	2006	16228
Physic	ian	Decedent's Name (First, Middle, Last)					-	2. Date of D	Da	y Year	3. Time of Death
/Medi		Frederick C. Reese						MAY	21	2004	
Exami	ner	4a. Facility Name (If not institution, give street	11 -11.	2.5		4b. City, Town, c	or Location of Deat	h -	40	County of Deal	n d
Funeral		5. Social Security Number 6. Sex		(In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bi	rth	9. Bin	hplace (State or Foreign
Director		212-07-7077 1 ⁻¹	2□ F	92	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D Jan. 1	2,76	.914 Mar	yland
pug *		Usual Residence of Decedent 10a. State 10b. County		10c, City.	Town or Loc	ation					10d. Inside City Limits
Maryla f sho	ō	Maryland Harford		Bel							1 ☐ Yes 2X No
r 28e-	Director	10e. Street and Number		DCI	Z 1	10f. Zip Code			10g. Cit	tizen of What Co	puntry?
th with	a D	1615 Prindle Drive				210	15			USA	
r dea	Funeral	11. Marital Status	Vas Decedent E		. 13. W	as Decedent of F Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	pecify Yes or N o Rican, etc.)	0-	14. Race - Ame Black, Whit	
s afte	by Fi	If	☐ Yes 2 ☐ No fYes, Give ∕ear or Dates:	lo	1	□Yes 2DXNo	Specify:			Specify: Wh	ite
IIIG A I A 13-0030 be filed within 72 hours after death with the Maryland lat Hygiene. d other than "naturel", or Items 23e or 28e-f show event, I'm Medical Examinational Le notified at	ted	15. Decedent's Education	n			ent's Usual Occup			16b. K	ind of Business	
thin 7:	Completed	(Specify only highest grade con Elementary/Secondary (0-12)	npleted) College (1-4or 5	+)	life. D	O NOT use retire	during most of wo d)	rking			
led wi lygien her th		8			Expe	diter	18. Mother's Nar	m a /Final Billion			anufacturer
otal H ed oti	Be	17. Father's Name (First, Middle, Last)								i Sumame)	
should and Men	L _O	Frederick (nmn) Reese 19a. Informant's Name/Relationship (Type, F			19b. Mailin	g Address (Street	Mary (nm			or Town, State, 2	Zip Code)
0 = 0	1	James F. Dietz / Frie	end		1615 E	rindle D	Orive, Be	l Air.	Marv	land 21	015
ges 1 and of Health If item 27 or other tr		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Remo	val from State	20b. Pla	ice of Dispos	ition (Name of atory or other pla		Date		ocation - City or	
attimor mit. Pages partment of I portent: If it y Injury or o		' 4 ☐ Donation 5 ☐ Other (Specify)	var iroin olato	High		cmorial		4-06	-	lston, 1	Maryland
Dattimory permit. Pages Department of I Importent: If ite any Injury or or once.		21. Sign turn of Funeral Service Licensee	2				ineral Ho				
		23a. Part 1. Enter the disease, or complication	ons that cause	the death.	Do not ente	117 Cokes or the mode of dyi	sbury Roa	d, Abin	adon arrest,	, Maryl:	Approximate
Physician		shock, or heart failure. List only one ca Immediate Cause (Final	use n each in	ιθ.	0	x/ I	einers	Da		,4,5	Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Sue to (or as	a conseque	ence of):	A134	ermers	De!	ne	CHA	years-
Examiner	١.	Sequentially list conditions, if any, leading to immediate	_								
1sit	nine	cause. Enter Underlying	Due to (or as a	a conseque	ence of):						
be executed iclan and burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as	a conseque	ence of):						
	<u>~</u>	d									
The COTIDS, P.O. BOX 00 of The law requires that the death certificate I are has been signed by the attending physionage 2 should be detached for use as the b	Physician/Medic	IF FEMALE:									
ath ce	lan/	23b. Was decedent pregnant	f yes, outcome I□Live birth	2 Fetal o	death 3 🗌	Ectopic pregnanc	y			23d. Date of del Month	ivery Day Year
the a	ysic	1 Voc 2 No	t□Pregnant at 9□Unknown	time of dea	ath 5∐	Other (specify) _					,
that the ed by detac		Part II. Other significant conditions contribu	iting to death bu	ut not resul	ting in the un	derlying cause giv	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
w requires been sign should be	d by	Proumania						10	Yes 2	□ 100 3 □ Pr	obabiy 4 🗆 Unknown
law rec	piete	To-luce to	the	INE	>_			24a. Wa		24b. Were au	topsy findings available completion of cause of
	Completed	al and X	-18	0				auto perf 1 Yes	ormed?	death?	
VICAL icien: 1 certificat ector, p	Be (25. Wa e err to me i - examiner?	HON	4		-	26. Place of Dea	ath (Check only	one)		
Of N Physic this c	2	1 ☐ Yes 2 ☐ No Hospi 27. Manner of Death 28	^{ital:} 1 ☐ Inpatie 8a. Date of Injur		R/Outpatient 28b. Time of	3□ DOA Ott		lome 5 ☐ Res 28d. Describe		6 Other (Spec	cify)
ding ding h. After funer	tion	Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	Wo	rk?]Yes 2□No	280. Describe	now inju	ry occurred	
LIVISION I or Attending after death. Director: Afte	ifica	2 Could not be	8e. Place of Inju	ıry - At hon	ne, farm, stre	et, factory, office		28f. Location	(Street ar	nd Number or Ru	ıral Route Number,
s afte	Certification:	4 Homicide	building, etc	с. (Specify)				City or To	iwn, State	9)	
Hospi 4 hour Funer ely fill	edical	29a. Certifier 1 Certifying Physicia (Check only 2 Medical Examiner:	On the basis of	examination	rledge, death on and/or inv	occurred at the ti	ime, date and place opinion, death occu	, and due to the irred at the time	cause(s date and) and manner as d place, and due	stated. to the cause(s)
DIVISION OF VICE To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific, completely filled in by the funeral director,	Med	one) 29b. Signature and title of certifier	and manner sta	ited.		29c. Licens	se number		29d. Da	te signed (Monti	h, Day, Year)
<u> </u>) Mail	MARC		A 40	D	19500		41	- · · · · · · · · · · · · · · · · · · ·	2501
10		30. Name and address of person who comul-	ed cause 1 de	eath (Item	<i>VVII)</i> 23а) (Туре, Г	Print)	01-1	Cl	<u></u>	MY 21	1.2006
Ψ		Manuel M.	42	hi	nj	? .	8 LOW	3 MAC	40	Moer	deen/
St Regis	ate	31. Date filed (Month, Day, Year) MAY 2 3 2006	32. Registra	ars Signatu	ILO TLO	nested	γ (ζ	/	. 0[/	-100	
110915	120	WELL \$ 0 5000	No. of the last	Person d	100	Appear					

			1 - State Registrar	State of M	arylan		artmen rtificat			and Me		giene Reg. No.	006	152	29
	Physic		1. Decedent's Name (First, Middle James		arl			Rode	gers		2. Date of Dea Month 5	Day	2006	3. Time of E	
	/Medi Examir		4a. Facility Name (If not institution 5719 Denwood				-	Town, or altir	Location o	f Death		4c. Co	ounty of Death		
	Funeral Director		5. Social Security Number 240–68–1798 Usuaf Residence of Decedent	6. Sex 7. Ag 1 ▲ M 2 ☐ F	62 (In yrs. 1	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da) 2-13	v. Year)	9. Birth Co.	nplace (State or untry) N.C.	Foreign
	e Maryland a-f show lifted at	ctor	10a. State 10b. County Md. N.	A	1	y,Town orLo Baltimo								10d. fnside City 1X Yes	
	with th	Director	10e. Street and Number 5719 Denwood	Avenue			10f. Zip	Code 2120	16			-	of What Col	untry?	
9600	72 hours after death with the Maryland "natural", or Iteme 23a or 28a-1 show calcel Examiner mast be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Marr Muldowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 3 ☐ ff Yes, Giver Year or Dates:			f Yes, spec 1 ☐ Yes	dent of His offy Cubar 2 X No	spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	city Yes or No- lican, etc.)	14.	Race - Amer Black, White pecify: B.	lack	
Maryland 21215-0036	a within 72 ho piene. r then "natur the Medical	Completed	15. Deceden (Specify only highes Elementary/Secondary (0·12) 12th grade	cs Education at grade completed) College (1-4or s	5+)	life.	dent's Usua kind of wo DO NOT us semble	rk done d se retired)	uring most	of workin	g		of Business/I		
d 2	filed Hygi ther	Be Co	17. Father's Name (First, Middle,	Last)		ADE	empt.	ey Lu		r's Name	(First, Middle,		neral :	MOLOES_	
ylaı	should be and Mental s marked o umatic eve	To	HD		Rodg	gers, S				essie				odgers	
Mai	tra tra		19a. Informant's Name/Relations Gertie R. Lew		er						Route Numbe	r, City or To 207!		ip Code)	
Baltimore,	item item otha		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 □Removal from State	20b. P	lace of Dispo emetery, crer King Me	sition (Nam natory or o	ne of ther place	-	Da 5-22	ite	20c. Locat	ion - City or T	own, State	
Balti	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service		ا		. Name an	d Address	s of Facility	1	Ba	ltimo	re, Md North	. 21202	
8760,	death certificate be executed Medical Mam de attending physician and defor use as the burial-transit	dical Examiner	Immediate Cause (Finaf disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. METAS Due to (or as b. Due to (or as c. Due to (or as d	a consequ	uence of):	OSTA	TE.	CA!	RCIA	UO MA			Onset and De	EAR
P.O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pro					23d.	. Date of delive Month	ery Day Ye	ear
	S 5 9	þ	Part fl. Other significant condition	ns contributing to death b	ut not resu	Ilting in the ur	nderlying ca	ause givei	n in Part I.			bacco use o		the cause of dea	
Division of Vital Records,	The law ate has b page 2 s	Completed								_	24a. Was a autops perform	y .	4b. Were autoprior to codeath?	opsy findings avompletion of cau	railable ise of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othor			Check only on				
ion of	ing Wher	atlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date of Inju		28b. Time of Injury		8c. Injury Work	at	28	e 5 Reside			fy)	
Divis	irection by the A	Certification;	3 Suicide 6 Could r 4 Homicide determine		ury - At hor c. (Specify	me, farm, stre	eet, factory	, office		28	f. Location (St City or Town	reet and No	umber or Run	al Route Numbe	97,
)	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifyin (Check offin) 2 Medical I	Physician: To the best of examines: On the basis of and manner sta	examinati	wledge, death ion and/or inv	occurred a estigation,	at the time in my opi	o, date and nion, death	place, an	d due to the call at the time, d	ause(s) and ate and pla	d manner as s ce, and due t	stated. o the cause(s)	
	Tott com	Σ	29b Signature and title of certifier				.1	License	519	46		TAY,	gned (Month,	2006	6
•	Ó		30. Name and address of person POBERTO PILI	who completed cause of di JOHNS HOPM 3 2006 32 Pegistra	eath (ftem	23a) (Type, I 165911	Print)	1011	N. BR	OADA	114 R.	ALTIN	YORE I	MD 212	31
	Sta Registr		31. Date filed (Months Dev Your)	3 2006 32 Angistra	ar's Signat	O San	ange)				, ,,	, , , ,			

		•	1 - For State Registrar	State of M	aryland		artment rtificate					giene Reg. No.	106	162	30
	Physici	an	1. Decedent's Name (First, Middle, Las								2. Date of Dea	ath	Year	3. Time of	
	/Medic	al	Vivian Franz Reyr				4h Cihi T	roug 00	Location of	of Dooth	May 16		U6 ounty of Dea	3:30P	M
	Examin	er	4a. Facility Name (If not institution, give		lobin					or Death					
	Funeral		Morningside House 5. Social Security Number 6. Se	7. Ag	e (In yrs. la	ast birthday)	If Under Months	anov 1 Year Days	If Under Hours	24 Hrs.	8. Date of Birt	h	ne Aru	thelean /Chite	or Foreign
	Director		33	□M X XF	81	Yrs.	WOTHING	Days	Tiodis		(Month Da	2247		Michi	.gan
	ow ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside Cit	ty Limits
	a-t sh	ctor	MD Anne Arus	nde1	Se	evern								1 ☐ Yes	XX™
	or 28	Director	10e. Street and Number 1261 Colonial Parl	- D			10f. Zip	Code				10g. Citize	n of What Co	ountry?	
	eath v	erai	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13. V			spanic Ori	ain? (Spe	cify Yes or No-	- 14	USA Bace - Ame	erican Indian.	
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other treumetic event, the Madical Examinar must be notified at or other treumetic event, the Madical Examinar must be notified at	by Funerai	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4X ② Divorced	Armed Forces? 1 Yes 2 4 ff Yes, Give Year or Dates:		1	f Yes, spec 1 ☐ Yes ² 2		n, Mexicar Specify:		cify Yes or No- Rican, etc.)		Black, White	le, etc.	
5-0	72 ho 'natur	eted	15. Decedent's Ed (Specify only highest gra			16a. Deced (Give	dent's Usua kind of word DO NOT use	f Occupa	ation during mos	t of worki	ng	16b. Kind	of Business	/Industry	
12	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		r Edi)			US :	NAvy		
<u>0</u>	illed Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle,				
ylar	should be nd Mental marked c	To E	Herman Franz						Bert	tha F	luber				
Mar	12 sh h and 7 Is m treum		19a. Informant's Name/Relationship (7								I Route Numbe				
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Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tre 2002.		21. Signa pruneral Service Lice	1-	18		Finkane 426 C				P.A. Glen Bur	rnie.	MD 2	1061	
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8	Physician		fmmediate Cause (Final disease or condition resulting in death)	a	au	new	la							Onset and D	Jeath
В	/Medical Examiner		Tosaking in sealiny	Due to (or as	a consequ	ence of):									
	1	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ence of):									
	acuted ind transit	amir	that initiated events resulting in death) Last	c											
8760,	cate be executed physician and the burial-transit	dicai Examiner	resulting in death) cast	Due to (or as	a consequ	ence of);									
687	ficate physis the			. d											
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rds	w require been sig should b										1 □ Y	'es 2 □ I	No 3∏Pr	obably 4 U	Inknown
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Examine		4a. Facility Name (If not institution, give street and number) Nouthwest Hospital		-	Location of Death	`	4c. County	of Death
Funeral Director		212-40-2696 1 1 M 2 F 72	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Nov. 1	Year)	9. Birthplace (State or Forei Country) Maryland
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ben ken		10e. Street and Number		10f. Zip Code		1	-	What Country?
- 1	by Funeral	6824 Campfield Road 11. Marital Status 1 ★Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever Amed Forces? 1 ★Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Bla	ISA ce - American Indian, ck, White, etc. cy: white
then	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of work.	ing		ore County Sc
o pd	To Be C	17. Father's Name (First, Middle, Last) Frank A. Serio			18. Mother's Name	ne C. Se		ne)
in and Men i7 is marke treumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a	and Number or Aura	al Route Number	City or Town,	, State, Zip Code)
27 is		John C. Serio - Brother	6824	Campfield	l Road Ba	ltimore	Mary1	and 21207
if Item 2 or other		20a. Method of Disposition 2 ☐ Removal from State 2	Ob. Place of Dispo) (e	Date	20c. Location	- City or Town, State
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Sta Registra		30. Name and address of person who completed cause of death Jenniters Yorke Do Northwest 31. Date filed (Month, Day, Year) MAY 2 3 2006 32 Registrars:	Hospital	Print) 5401 OLD	court F	Rd. Rai	ndallsta	mn MD 5113

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20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - (Comparison of the place)	City or Town, State
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1 Burial 2 Cremation 3 Removal from State 4 Donation 5 XOther (Specify) Entombment Loudon Park Maus. 5/22/06 Baltimore 22. Name and Address of Facility Hubbard Funeral How 4107 Wilkens Avenue, Baltimore, Market Market 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 10	ome, Inc. arvland 21229
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between
Physician Immediate Cause (Final disease or condition resulting in death) The disease or condition resulting in death) The disease or condition resulting in death) Due to (or as a consequence of):	Onset and Death
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TIF-FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ tive birth 2 □ Fetal death 1 □ tive birth 2 □ Fetal death 1 □ tive birth 3 □ Ectopic pregnancy Mon	e ol delivery nth Day Year
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27. Manner of Death 1	nner as stated. und due to the cause(s)
29b. Signature and title of certifier Attending 29c. License number 29d. Date signed	(Month, Day, Year)
Bun 1. MM MD Physician 125861 65/16	7/06
30. Name and address of passen who completed cause of death (from 22a) (Time Print)	Herela I and
12+1 Bruce R. Mc Curdy MD. 716 Manden Choice Cane State 101 Bathmore,	Marylana 7127X

Please	Type or Print in Black Indelible Ink. Ensure A	All Copies Are Legible.	
For	State of Maryland / Department of Health and	Mental Hygiene 2006	162
1 - For State Registrar	Certificate of Death	Reg. No.	
1. Decedent's Name (First, Middle, Las	(1)	2. Date of Death	3. Time of Death
CEODGE MATIL	TA STMMONG	May 22 2006	7 - 45 7

/Medical Examiner

ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Box 68760, P.0. as been signed 2 should be de ivision of Vital Records, pag After this certificate the funeral director, death. Director:

Physician 7:45 AM GEORGE MALUIA SIMMONS 22,2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 8330 Philadelphia Road Rosedale Baltimore 8. Date of Birth (Month, Day, Year) June 20,1943 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 62 Yrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min. 1 MM 2 □ F Yrs. 215-44-2084 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow nit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar artiment of Health and Mental Hygiens artiment of Health and Mental Hygiens or ortent: if Hear Taraked other than "naturel", or liteme 23a or 28e-1 ehow injury or other traumatic event, it a Medical Examinating to incitied at 1 ☐ Yes 2 No Baltimore Director Rosedale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8330 Philadelphia Road 21237 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 Yes 2 No <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) McClean Contracting Co. Elementary/Secondary (0-12) College (1-4or 5+) Engineer Estimater 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) George William Simmons Virginia Seaton Akers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8330 Philadelphia Road-Rosedale, Maryland 21237 Mary Joy Simmons Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Evans Funeral Chapel 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: if eny injury or once. 5-24-06 Forest Hill, Maryland Bel-Air 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 8800 Harford Road-Parkville, MD 21234 marae Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MIENSIUN Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner CHOLESTREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ARRETUR かいとかりに Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ABUNE RACCO 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed 2/2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death |Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 15 Residence 6 Other (Specify) 1 Yes PNo Medical Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 🗌 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 | Homicide within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number

D—W 80 2 5 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who complet d cause of de th (Item 23a) (Type, Print) Cheraco Aux A 1224

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 2

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32 Registrar's Signature

15:0 F. W.

David Antonio Snow

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 16234

		1- For State Certificate of Death Registrar	Re	eg. No.	
Physicia	ın/	Decedent's Name (First, Middle,Last)	Date of Deat Month	Day Year	3. Time of Death 1853 hrs
ledical Exami		DAVID ANIONIO BNOW	May 9, 200		
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Sinai Hospital Baltimore		4c. County of Death	1
engar saara		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8 Date of Rid	th(MM/DD/YYYY) 9 Bir	thnlace (State or
Funeral Director	İ	Name David Harry Mary	1	Foreig	in
Birector	ļ	218-98-6844 1XM 2F 24 Yrs. Months Days Hours Min.	04/	17/1982 ^{co}	untry) MD
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th the Maryland 23a or 28a-f sho notified at once.	Director				
oth th	ä	1623 BALMOR CT. 21217 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	USA - 14. Race - Ameri	ican Indian, Black,
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her de	/ Fun	1 Yes 2 X No 3 Widowed 4 Divcrced If Yes, Give Year 1 Yes 2 X No specify		Specify BL	ACK
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Baltimore, Moemit. Pages 1 and 2 Department of Health Important: If tem 2 Injury or other traue		1 X Burial 2 Cremation 3 Removal from State crematory or other place)			
tim Pag tment rtant:	ļ	Trinity Cemetery May 1 21. Signature of Fútheral Service Licensee (22. Name and Address of Facility Wire)	19, 2006	Dundalk, MD	
Baltimo permit Page Department o Important: injury or oth		WILL	SLEY CI	HAVIS, JR	. FUN. HM. MD 21231
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Division of Vital Records, rat or Attending Physician: The law requirers after death all Director: After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2 should be all the funeral director, page 2 should be all the funeral director.	i.	27 Manner of Death 28a Date of Injury 28h Time of Injury 28c Injury at Work?	28d. Describe I	now injury occurred	
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ViSi or Att frer de Direct in by	ij	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S	Street and Number or Ru	ral Route Number, City
Diví pital or ours afte eral Dir	Certification:	4 Homicide determined (Specify) Local Street		uantico Ave, Baltin	nore, MD
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To th withir compl	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated	t trie time, date		
	Ž	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mo	пш, µау, теаг)
		Carlo C / Carlo		10, 2006	
2		30 Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	1		
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State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 18, 2006 9:02 May Dorothy J. Shabek /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Hunt Valley 400 Symphony Cir. Unit 8. Date of Birth (Month, Day, Year) June 23, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🛱 F Days Hours Min. 81 Yrs. Maryland 212-20-4725 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Baltimore Hunt Valley Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Cir. Unit 305 21030 USA 400 Symphony Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Life Insurance N/A Secretary 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marie H. Barnickol Joseph H. Jaecksch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 400 Symphony Cir. Unit 305 Hunt Valley, MD 21030 Shabek/Husband Anthony 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition metro Crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State May 19, * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 2006 21. Signature of Funeral Sende Doensee

Michael 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, J. Flagle 10 W. Padonia Koad Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Longostre resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iffinity that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month. 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No ² 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 18/06 an a w 1032543 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St. Suite 4106 Baltimore, MD MD Dr. Mark Stromberg, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2006 Registra

Funeral

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Baltimore, Maryland 21215-0036

		•	1 - For Registrar	State of Maryla	•	artment of H			iene g. No.)5	162	36
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat		Voor	3. Time of [Death
	Physicia		Alma MYRTLE		Smelgu	ıs		Month 5		Year 106	4:10	P M
	/Medic Examin	5 2	4a. Facility Name (If not institution, give stre				Location of Deat	h	4c. County of	of Death		
	_Aumin		Millénium Nursing	Home		Glen Bu	rnie		Anne	Arun	de1	
4	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	Voor	9. Birthpl Count	ace (State or	Foreign
	Director		218 - 22 - 3289 1□ M	2 ₹ F 83	Yrs.	Months Days	Hours Min.	6-27-192	22	Count	"W Va	
	ס		Usual Residence of Decedent									
	nylan how	_	MD 10b. County Anne Aruno		ity, Town or Lo Glen F					10	od. Inside City 1 ☐ Yes	
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	death with the Maryland me 23a or 28a-f ehow rinual by ricilitied at	Funeral Director	204 9th Ave. SE			2106			USA			
	ame erm	nei	TT. Marker Clares	Was Decedent Ever in 9 Armed Forces? 1 Yes 2 2 No	U.S. 13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer	Specify Yes or No- to Rican, etc.)		- America , White, e		
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Z	be filed within 72 hours after death with the Marylan all Hygiene. Ide Hygiene. Ide other than "natural", or Itame 23a or 28a-1 show other than "natural", or Itame 23a or 28a-1 show avent, the Medical Examiner natal by notified at		17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, M	Maiden Surname	a)		
yland	ntal l	Be	, , ,	mples			Luci		ner	,		
ج	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 le marked other then "I tem 27 or other traumatic event, the Men	ို	19a. Informant's Name/Relationship (Type	*	19b Madin	ng Address (Street		ural Route Number		State Zin	Code)	
Z	d 2 s th an 7 le i		Mrs. Pam Boss / day			Valdo Rd.				J. 10, 17, 10	0000)	
ย์	1 an Heali em 2		20a. Method of Disposition	<u> </u>	Place of Dispo	sition (Name of			20c. Location - (City or Tov	wn, State	
2	ages nt of 		1 ☐ Burial 2 Cremation 3 ☐ Ren	oval from State	cemetery, cren	natory or other place. e Cremate		22/2006 S				
Бащто	rt. Particular		4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee	011		. Name and Addres						
מ	permit. Pages 1 and 2 Department of Health s Important: If item 27 li eny Injury or other tra once.		21. Signature of Punera Service Licenses	Ilder MO136				ingleton en Burnie	MD 210	. Home	e P.A.	
24	- W		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the dea	ath. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory arre	est,		Approximate Interval Betw	veen
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5	the either	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5	Other (specify)					,	
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	fler t	- - -	27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	k?	28d. Describe ho	w intury occurre	od		
<u> </u>	eath.	cati	2 Accident investigation				Yes 2□No					
DIVISION	or Ati	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, larm, str cify)	eet, lactory, office		28f. Location (St. City or Town	reet and Numbe s, State)	r or Rural	Route Numb	er,
2	urs al	Ce						<u> </u>				
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	ledicai	29a. Certifier 1 Cartifying Physic (Check only 2 Madical Examine	 ian: To the best of my kr r: On the basis of examinand manner stated. 	nowledge, death nation and/or in	n occurred at the tir- vestigation, in my o	ne, date and place pinion, death occi	e, and due to the ca urred at the time, da	ause(s) and man ate and place, a	ner as sta nd due to	ated. the cause(s)	
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	7		30. Name and address of person who com	MI) 2 XX	om zoa) (Type,	+ ANNYE	R C/- 1	2 - 10	e. RA	LTO.	MD2	1225
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		4	For State Registrar	State of Maryla	-	artment of F tificate of		Re	g. No.Z U U 6	16237
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1	Examin	er	4a. Facility Name (It not institution, give Baltimore Washing	ton Medical Ce	enter	4b. City, Town, o	Burnie	8. Date of Birth		Irundel
	Funeral Director		5. Social Security Number 220-24-9763 Usual Residence of Decedent	DM 2⊠F 77	s. last birthday) Yrs.	Months Days	Hours Min.	(Month, Day, Nov. 8,	1928 MD	thplace (State or Foreign ountry)
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	r 28a	Je .	10e. Street and Number	mac i	oron ba	10f. Zip Code		10	g. Citizen of What Co	ountry?
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036	s i and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If ealth and Mental Hygiene. Item 27 is marked other than "neturel", or iteme 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Amarried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cubin 1 ☐ Yes 2 ☑ No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ocity Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify: 1	
21215-0036	thin 72 hg e. an "netur Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give	DO NOT use retire	during most of works	ng 1	6b. Kind of Business	·
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nd	be fill htal H d oth	Be	17. Father's Name (First, Middle, Last) John Steven Roach				18. Mother's Name			
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Maryland	d 2 st th and t7 is r traur		19a. Informant's Name/Relationship (7 Mrs. Deborah Matth			•				Zip Code)
	1 and Health tem 27 other tr		20a. Method of Disposition		. Place of Dispo	sition (Name of			t0c. Location - City or	Town, State
Б	Page ent o nt: If ry or		1 ⊠Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	=	natory or other plac .rk Cemet	Mav.	23,	Baltimore	MD
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/ita	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?	LIhat		la	26. Place of Death	(Check only one)	
of \	Phys this al di	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	☐ ER/Outpatier 28b. Time of		4 Nursing Ho	me 5 Resider	nce 6 Other (Spe	ecify)
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)	.0		. S. Jano	a mb			22483		May 20	
	10		30. Name and address of person who come STURRE JAC	UBS MD 3	tem 23a) (Type.	epited D	o. Gler	Burny	e, mo a	1106/
	Sta Registi		31. Date filed (Month, Day, Year) MAY 2 3 200	32. Registrar's Sig	gnature	dist.				

			1 - For State Registrar	State of M		id / Depa	artmer	nt of H			ntal Hyg	2.0	0.6	16238
	≠ 05 393		Registrar 1. Decedent's Name (First, Middle, La	st)			incat	011	Jean	2	. Date of Dea	th	al ad	3. Time of Death
2	Physici	_	Marie F. So								Month May 1	5 200	Year	11:550 M
	/Medic Examin		4a. Facility Neme (If not institution, giv	e street and number	r)		4b. City,	Town, or	Location of		tiay i	4c. County		
	*		6918 Universi	ty Driv	е		1	Midd	lle R	iver		Balti	mor	е
	Funeral Director		5. Social Security Number 6. S 216-10-3453	ex 7. A □M 2 ⊠ F	kge (In yrs. 89	last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min. M	Date of Birth (Month, Day ay 25,	Year) 1916	9. Birth Cou Mar	place (State or Foreign intry) Cyland
	p s		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Aaryla Febo	ō	MD Baltim	ore			ddle	o Di						1 ☐ Yes 2 🛣 No
	28a-	rect	10e. Street and Number			F13		Code	ver			Iog. Citizen of \	What Cou	intry?
	3a or	Ö	6918 Universit	y Drive				2122	0			USA		
	death	ner	11. Marital Status	12. Was Deceden	t Ever in U	.S. 13.\				in? (Specia	fy Yes or No- can, etc.)		e - Ameri ck, White	ican Indian,
9	or Its	F	1 Never Married 2 Married	1 Tes XI					Specify:	1 0010111	can, etc./	Specify		nite
8	ural'.	d b	¥∏Widowed 4 □ Divorced	Year or Dates	:									
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow in Medical Exertiret most be notilised at	Completed by Funeral Director	15. Decedent's E (Specify only highest gra	ide completed)		16a. Deced (Give	dent's Usu kind of wo DO NOT u	al Occupi ork done d se retired	ation during most)	of working		16b. Kind of B	ısiness/Ir	ndustry
12	withi Bne. than	d L	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Home			,			own h	ome	
b	Hyg other	BeC	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (i	First, Middle,	Maiden Surnam	10)	
lan	Ald be Aenta rked tic sv	To B	Robert Ecker	t					Fra	ancis	s Capt	ain		
Maryland	and N		19a. Informant's Name/Relationship (19b. Mailir	g Address	(Street a				r, City or Town,	State, Zi	p Code)
Σ,	and and mark		Louis Soul /s	on		691	8 Ur	nive	rsity	/ Dr		altimo		
Baltimore,	Jes 1 1 of H If Iten		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □	Removal from Stat	e 20b. F	Place of Dispo cometery, cres rdens	sition (Na natory or o	me of other plac	e) + h	Dat 5 / 1 0		20c. Location -	•	
ij	tmen tant:		4 □ Donation 5 □ Other (Specia		00				,					
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amportant: If Item 27 is marked other than "natural Exercities must be notified at once."		21. Signature of Funeral Service Lice	M (An	MI	1/2	Conn	ell	y Fur	300 neral	Mace L Home	Ave. le of Es	3alt ssex	CO. MD 21221
*			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the deat line.	h. Do not ent	er the mod	de of dyin	g, such as c	cardiac or r	espiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Hear Due to (or a	t f	ilure								Onset and Death
4	/Medical Examiner		resulting in death)						4.1					
н		3r	Sequentially list conditions,	b. Due to (or a	ncer	uence of):	Met	25tz	tic					
Τ	nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 0										
/ 	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or a	s a conseq	uence of):								
760,	9 8	cai		d										
89	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE:											
Вох	ath ce	lan/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth	2 🗌 Feta	Ideath 3□	Ectopic p					23d. Dai	te of deliv	ery Day Year
<u>o</u> .	the a	ysic	1 ☐ Yes 2 ⊠No 9 ☐ Unknown	4□Pregnant 9□ Unknown	at time of d	eath 5∟] Other (s _f	pecify)						,
О.	that the deby	/ Ph	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying o	ause give	en in Part I.		23e. Did to	bacco use cont	ribute to t	the cause of death?
ds	lures n sign	d by	Atrial Fit	rillation							1 □ Y	es 2 No	3 Pro	bably 4 Unknown
00	w requires been s should	iete	Valvular h	eart di	SPUST	٥					24a. Was a	n 24b. \	Were auto	opsy findings available ompletion of cause of
Re	The law requires that the cete has been signed by the page 2 should be detache	Completed	7 0 1 1 4 4 1 1 1 1	CALC SI	16-67						autops perform	med?	prior to co death? I Yes	ompletion of cause of
ta		BeC	25. Was case referred to medical						26. Place	of Death (6	Check only or			2940
>	S s F	ToE	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpa	tient 2	ER/Outpatien	t 3 🗆 D	Othe Othe	ar: 4 🗆 Nur	sing Home	5 Reside	ence 6 □Oth	er (Speci	fy)
o uo	Attending PI r death. ector: After ti by the funera		27. Manner of Death 1 Total Statural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D	jury Day Year)	28b. Time of Injury	м	28c. Injun Work	rat c? Yes 2 □ N		d. Describe h	ow injury occurr	ed	
Division of Vital Records,	or Atter after des Director in by th	Certification:	3 Suicide 6 Could not be determined	286. Place of I	njury - At h etc. <i>(Specil</i>	ome, farm, str	eet, factor	y, office		281	f. Location (Si City or Town	treet and Numb n, State)	er or Ruri	al Route Number,
_	To the Hospital or Attending Phy within 24 hours atter death. To the Funeral Director: After thi completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifying Pl	nysicien: To the bes niner: On the basis and manner:	of oxamina	wledge, death	occurred restigation	at the tim	ne, date and pinion, death	d place, and h occurred	d due to the c at the time, d	ause(s) and ma ate and place,	nner as s	stated. o the cause(s)
	Fo the Mithin 2 Fo the comple	Me	29b. Signature and title of certifier	1				c. License			2	9d. Date signe	d (Month,	Day, Year)
			· handall	hrand			1	419	68			5/18/0	06	
	1		30. Name and address of person who	completed cause of	death (Iter	n 23a) (Type,	Print)		- 1		. (11.41	,	
	Q		Michael D. M		no	760 2	Be	law	Rd.	Bal	Ito. A	NO 212	36	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 3 20	32. Regis	trar's Signa	ature	A COLOR					5/18/0 ND 212		

06-03420 John Skahill, III

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

, , , , , ,	1- For State Convergiand / Department of Fleath and Wental Hygiene 1- For State Reg. No. 2006 623
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year May 20, 2006 3. Time of Death 0800 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1517 Adamsview Road 4c. County of Death Woodlawn Baltimore County
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
ow any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE WOODLAWN 1 Yes 2 X No
D 21215-0036 should be filled within 72 hours after death with the Maryland and Menial Hygene. is marked other than "natural", or items 23a or 28a-f show ratic event, the Medical Examiner mays be notified at once. To Be Completed by Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1517 ADAMS VIEW RD. 21207 USA
r death with the or items 23a must be noti	11. Marital Status 1
nours after contrain, or the contrain or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the contrainer or the con	3 Widowed 4 Divorced if Yes, Give Yeav IETNAM 1 Yes 2 No specify: Specify: WHITE
MD 21215-0036 d 2 should be filed within 72 hous thit and Mental Hygene. n 27 is marked other than "natu numnitie event, the Medical Exat To Be Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2 MEDIA SPECIALIST EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
D 21215-00% should be filed with and Mental Hygene. To marked other unatic event, the Med	JOHN JOSEPH SKAHILL, II DOROTHY HAYES
e, MD 21 t and 2 should Health and Me item 27 is ma tranmatic ev	BETTY SKAHILL - WIFE 45 JOHN ST., WESTMINSTER, MD. 21157
ore, s l an of Hea If iter	20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) MD VETERANS CEM. 20c. Location - City or Town, State CEM. 5/25/06 OWINGS MILLS, MD
	1. Significate of Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD.21157
Physician /Medical Examiner	23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Death Complications of head injuries Due to (or as a consequence of):
ner -	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):
vecuted t and transit :al Examiner	C. Due to (or as a consequence of):
© a a c	☐ AMENDED item#23a,27,28a-f,perME,G856,6/26/06 TT
Box 68760, death certificate be attending physici diffor use as the buriny sician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown
m 2 42 5	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown
Division of Vital Records, P.O. Ital or Attending Physiciau: The law requires that the rs after death all Director. After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by Pertification: To Be Completed by P	24a. Was an autopsy findings available prior to completion of cause of death?
tal Rectinant: The certificate ector, page	25. Was case referred to medical 26. Place of Death (Check only one)
f Vital Physician This cert al directo	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 V Other: Scene
ion of tending Pheath on: After the funeral ation: T	1 Natural 5 Pending Oct. 17 1997 11.15 pm 1 Yes 2 X No subject was beston
Division o spiral or Attending hours after death meral Director: Aft y filled in by the fune Certification:	Accident Investigation Accident Investigation Subject was beaten
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 21, 2006
	(No to b)
0	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY 20 2006 **Physician** 4:15 P M SALTZMAN MYRA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE STELLA MARIS HOSPICE TIMONIUM | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | Months | 12/27/1930 Birthplace (State or Foreign Country)
 7 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔽 F 75 75 Yrs. 212-26-1067 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worde ! rthen "natural", or itams 23a or 28a-f ehov It a Medical Examinar must be notified at 1 ¥Yes 2 No Director N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21209 USA 2700-D JENNER DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🏹 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 WHITE 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) marked other then College (1-4or 5+) CLAIMS SUPERVISOR SOCIAL SECURITY ADMIN. Maryland permit. Pages 1 end 2 should be fik Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic avens 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SACHS FRANK **EDYTHE** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 PONCE DE LEON AVENUE - CHARLESTON, SC 29407 PAUL SALTZMAN / SON Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State (ANSHE EMUNAH) AITZ CHAIM 5/22/2006 HALETHORPE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signatura of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part. Enjer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COLON CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Due to (or as a consequence of): attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Year Month Day 4□Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? res 2X No 2 No rs after deav...
ral Director: After this community by the funeral director, pe 1 Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE ŏ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b. 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 5/22/06 D4372j 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 3 2006 Registrar

DHMH 17 Rev 1/2001

20,

SALTZMAN

				State of Maryland / Department of Health and M	-	iene	10011						
1 - State Registrar Certificate of Death Reg. No. 2005													
5		Physicia	an	1. Decedent's Name (First, Middle, Last) Amelia Sichel	2. Date of Death	Day Year	3. Time of Death 7: 350 M						
		/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	11119	49- County of Death	1: 204						
35/				Charlestown Catonsville	e		10re						
		Funeral Director		$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	8. Date of Birth (Month, Day, 05/18/19	Year) 9. Birthpl	ace (State or Foreign try) PA						
		0 >		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			Od. Inside City Limits						
90		Maryia f shov	jo	MD BALTIMORE BALTIMORE			1 □ Yes 2 No						
2/14/06		or 28a	Funeral Director	10e. Street and Number 10f. Zip Code	10	og. Citizen of What Coun	try?						
1	:	s 23a o	rai	709 MAIDEN CHOICE LANE #104 21228		14. Race - America	USA						
B	(0	r Item	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ② No	Rican, etc.)	Black, White, e	etc.						
Ĺ	003	n 72 hours after death with the Marylar "natural", or Items 23a or 28a-f show salcal Evaniner must be notified at	þ	3 MWidowed 4 □ Divorced Year or Dates:		Specify: WHITE							
SICHEL	15-	within 72 hours after death with the Maryland ene. Han "natural", or items 23a or 28a-f show the Medical Evaninar must be neithed at	piete	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of works file. DO NOT use retired)		16b. Kind of Business/Industry							
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4	and	d be fill inital H ed oth	Be	17. Father's Name (First, Middle, Last) LOUIS GUTMAN 18. Mother's Name			ARUCH						
ELI	aryl	shoul and Me s mark umati	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura									
3	≥ .	and 2 fealth m 27 I		MICHAEL A. SICHEL / SON 4923 PLEASANT GROVE RO									
SA	nor	ages and of h		1 Rurial 2 Cramation 3 X Removal from State		-	Location - City or Town, State						
MRS AMELIA	3altimore, Maryland 21215-0036	Physician /Medical Examiner		21. Signature of Juneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC.									
	_			8900 REISTERSTOWN RUAD - PIKESVILLE, MD 21208 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate									
				shock, or heart failure. List only one cause on each line. Interval Between Onset and Death									
				disease or condition resulting in death) a. ATTELOSCIEVE FIC CAT A 10 VASCIVIAT A 118 A 18 Due to (or as a consequence of):									
			às.	Sequentially list conditions, January John Mark Dusto (or 58 a consequence of)									
	W		Examiner	Sequentially list conditions, if any, leading to finite diate cause. Enter Underlying Cause (Disease or injury that initiated events c									
	760,	ate be executed nysician and he burial-transit		resulting in death) Last Due to (or as a consequence of):									
	_	tificate big physic as the b	edical	d									
	XO	eath certifica attending ph for use as tt	an/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delive							
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	٥.	ires that the signed by detaction	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	acco use contribute to the cause of death?								
	ords	w require been sig should b			1 ☐ Yes	1 Yes 2 No 3 Probably 4 ⊕ Nown							
	3ec	hasbu	Completed	24a. Was an autopsy perform	y prior to con	psy findings available apletion of cause of							
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	of V	ding Physician: The la' h, After this certificate has funeral director, page 2	2			nce 6 □Other (Specify)						
	ono		tion:	27. Manner of Death 1 Thatural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No									
	Division of Vital Records,	af or Attanc	Certification:	e Cloude S Could get be									
		To the Hospital or Attan within 24 hours after deat To the Funaral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
		To the Hospital of within 24 hours af To the Funaral D completely filled in	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.									
		To t To t	Σ	29b. Signature and title of cartifier 29c. License number	29	9d. Date signed (Month, L							
		. 1		30. Name, and address of person who completed cause of death (Item 23a) (Type, Print)	^	e Baltimore MD 21228							
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		Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 2 3 2006	,	,							
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State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Martin 8:30AM repers 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 934 Long Cove Road Anne Arundel <u>Glen Burnie</u> If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 15 1942 Birthplace (State or Foreign Country) **Funeral** 1 MM 2□ F Months Days Hours Yrs. 219-40-4492 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits e how rthen "natural", or items 23a or 28e-f eho Maryland Anne Arundel Glen Burnie 1 Yes 2 No **Funeral Director** 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 934 Long Cove Road 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify white 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Gas & Electric permit. Pages 1 end 2 should be filed v Department of Health and Mental Hygien importent: if them 27 ie marked other 11 any injury or other treumatic event, the once. Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Martin Schepers Sr Lenora Perica ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Rosalie A Schepers 934 Long Cove Soad Glen Burnie MD 21060 spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta Metro Crematory Inc 5/26/2006 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Stallings Funeral Home P.A. <u>3111 Mountain Road Pasadena MD 21122</u> 23a. Pert1. Enter the disease, or compli-shock, or heart failure. List only or ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed CDDue to (or as a consequence of): Box 68760. attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□ Pregnant at time of death 5 Other (specify) P.O. should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b autopsy performed 2 | No 1 Yes 1 Tyes Division of Vital or Attending Physician: director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After the funeral 28a. Date of Injury (Month, Day Year) 27. May er of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: / 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) title of certifie 5/22/06 who completed cause of death (Item 23a) (Type, Print Glen Burnie MD 21061 Stephan 1 31. Date filed (Month, Day, Year) MD 32. Apgistrar's Signature State 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 4c per doc 9856 6-14-06 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year KOURTENA 9.57 PM **Physician** THAR 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard Examiner olumbi Countr Yen Howard Koz If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) AUG 7, 1981 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1□M 2√F 228-27-6307 24 Yrs. Virgínia Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23a or 28a-f show other traumatic event, the Medical Executed count by notified at 1 ☐ Yes 2 No Director Maryland Howard Columbia 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 10200 Owen Brown Road 21044 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: <u>م</u> 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "ne eny injury or other traumatic event, the Media once. Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nelson Bruce Tharp Leslie Patricia Condon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelson Bruce Tharp/Father 10200 Owen Brown Road Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 5/23/06 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee Edward A Gregorchik

299 Frederick Road Baltimo

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner bete hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit De (0) Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown After this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2 ☑ No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No Certification: To 2 ☐ ER/Outnatient 3FT DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. filled in by the fu 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours eff To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number wic 26830 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, Year) MAY 2 3 32 Registrar's Signature State 2006

Registrar

State of Maryland / Department of Health and Mental Hygiene											
			1 - For State Registrar	State of Iviarylar	ate of Death	Reg. No. 2 0 0 6 1 6 2 4 4					
			Negistrar Name (First, Middle, La	st) .	00/11/100	210 07 204.77	2. Date of De		3. Time of Death		
	Physici		Irone F.	Taylor			Month	21,200%	9:15 M		
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number) Apt	4b. C	ity, Town, or Location of Deal	th	4c. County of Dea	th		
		34 .	2503 Viole	27 Ave #6	035 E	saltimor	e	N/	A		
	Funeral	200	5. Social Security Number 6. S	ex 7. Age (In yrs. ☐ M 20 F	. last birthday) If Un Yrs. Month	der 1 Year If Under 24 Hrs ns Days Hours Min	. A (Month, Da	th 9. Bir	thplace (State or Foreign ountry)		
74	Director		Usual Residence of Decedent	63	113.		Aug.d	2, 1742 141	aryland		
	yland		10a. State 10b. County	10c. Ci	ity, Town or Location				10d. Inside City Limits		
	a-fst	ctor	Maryland NI	A	Baltin	10re_			1 XYes 2 No		
	or 28	Funeral Director	10e. Street and Number	- 1 #	10f.	Zip Code		10g. Citizen of What Co	ountry?		
	ath w	rai	2503 VIDLET	Ave. 603	35	2/2/5		US	<u>H</u>		
	Item Item	une	11. Marital Status 1 ★ Never Married 2 → Married	12. Was Decedent Ever in L Armed Forces? 1 Yes 2 X No	If Yes, s	cedent of Hispanic Origin? (S specify Cuban, Mexican, Puer	rto Rican, etc.)	- 14. Race - Ame Black, Whit			
980	urs af	þ	3 □Widowed 4 □Divorced	If Yes, Give Year or Dates:	1 🗆 Yes	s 20 No Specify:		Specify: R	lack		
215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show aleat Examiner must be natilisd at	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. Decedent's U	Isual Occupation work done during most of wo T use retired)	orkina	16b. Kind of Business	/Industry		
21	within lene. then "	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	Mife. DO NO			Maint			
121	filed with Hygiene. Ither ther	To Be Cor	17, Father's Name (First, Middle, Last		Iviar	18 Mother's Na	me (First Middle	Maiden Sumame)	nance		
ano	Mental i		Edward D	DOOR TAIL	lar	Trov	0) ulans			
Maryland	2 should and Mer is marks sumatic	F	19a. Informant's Name/Relationship (Type, Print) (Son)	19b. Mailing Addre	ess (Street and Number or R	Tural Route Number	er, City or Town, State,	Zip Code)		
_	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Mcdical Exeminal must be notified at		Mr. Warren	Taylor	3011	Glenmor	e Ave	Balto.	Md. 21214		
ore	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		Place of Disposition (/ cemetery, crematory of	Name of or other place)	Date	20c. Location - City or	Town, State		
altimore	nit. Pages lartment of ortant: If it injury or o		4 Donation 5 Other (Special	y)	VIt. Carr	nel six	1/2006	Dundal	K. IVId.		
Ball	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Linuss Funeral Home, P. A.								
*	20244	\vdash	YAND A: MULLY 2222 W. North Ave. Baito, Md. 21216								
JA.	2hyololon		23a. Part Enter the disease, or complications that each death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final						Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consec							
н	Examiner	Examiner	Sequentially list conditions	b. Co	ngative l	want failur	e				
	\$ 64 €		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	dueaix						
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760	eath certificate be executed attending physician and for use as the burial-transit	calE	l l	d							
68											
Вох	th cert endin	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 Live birth 2 Fet	c pregnancy			23d. Date of delivery			
	e dea	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of of 9☐ Unknown			Month	Day Year			
P.0	that the de led by the a detached f	Phy	9 Unknown Part II. Other significant conditions	contributing to death but not re-	sulting in the underhin	a cauco awan in Part I	23a Did to	obacco use contribute to	o the cause of death?		
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cor			Schi zupl Hyperte	an 24b. Were a	24b. Were autopsy findings available						
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ita	ician: Th certificate rector, pag		25. Was case referred to medical	, , ,	mea.	26. Place of De	1 Tyes Path Check only o	-	2 12 NO		
of <	d is	To B	examiner? 1 🗆 Yes 2 🗗 No		ER/Outpatient 3	DOA Other: 4 Nursing H	Home 5 Resid	dence 6 □Other (Spe	ecify)		
	ding Ph	Certification:	27. Manum of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	now injury occurred			
Division	ttendi death. ctor; A / the fu		2 Accident investigatio 3 Suicide 6 Could not b	e Con Diagnot Initiate At h	M 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office 2				28f. Location (Street and Number or Rural Route Number,		
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ā	spital or Attenous after de hours after de insral Directo y filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best of my kn	owledge, death occurr	ed at the time, date and place	e, and due to the	cause(s) and manner as	s stated.		
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Ö	To the Hospital or Attent within 24 hours after deatl To the Funsral Director: completely filled in by the	Medical Certi	29a. Certifier (Check only 2 Medical Example) 29b. Signature and title of certifier	niner: On the basis of examina	ation and/or investigat	ion, in my opinion, death occi	urred at the time,	cause(s) and manner as date and place, and due	to the cause(s)		
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State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician MAY 20,2006 4:31 a M ADELICIA VILLAGARAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTITIONL

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birth | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. Country | 1. C BALTIMORE 9521 FOX FARM ROAD 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 20F 45 Yrs. 215-84-0690 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County •how rthan "natural", or itama 23a or 28e-f shor the Madical Expulper outst be notified at 1 Yes XXNo BALTIMORE BALTIMORE MD. Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 U.S.A. 9521 FOX FARM ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Spec PUERTO RICAN Specify: ģ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTING FIRM ADMINISTRATOR of Health and Mental Hygilitem 27 is marked other rother treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental ISAIAS TIRADO ROGELINA RAMOS ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEROGE VILLAGARAY, SR. 9521 FOX FARM ROAD, BALTIMORE, MD. 21236 timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) = 5 SACRED HEART OF JESUS 5/24/06 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC BREASI CANCER /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine ettending physicien and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): 68760. Physician/Medical P.O. Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4 Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ sign be 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No rector, page 2 s 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Dirac completely filled in by 4 - Homicide To the Hospital 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D16619 may 23, 2006 Cunpulyours 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C-VERGARA - SOARES FRANKLIN SOUDRE DR. BAUTIMORE MD 21231 9940 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registres Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1038 **Physician** Wayne Franklin Williams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** n/a 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Month, Day, Ye. 4/29/1947 If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Min 1⊠M 2□F 59 216-44-4774 Yrs. Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "neturel", or iteme 23a or 28a-f ehow MD 1 X Yes 2 ☐ No n/a Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1217 Berk Ave 21237 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: δ Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2+^{College (1-4or 5+)} Elementary/Secondary (0-12) Social Security Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Williams Jovce Maddrix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: if item 27 la eny injury or other trea QDCB. 185 East Sunset Way Apt 2B Issaquah WA 98027 Kevin Williams / son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State West Mrunder Crematory 5/23/2006 Odenton, Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. Br Funeral Service 1328 Sulphur Spring Rd Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of) physician and s the burial-transit ROT Exam resulting in death) Last Due to (or as a consequence of) Physician/Medical attending I 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of de-th? ۾ 1 ☐ Yes 2 ☐ No 3 Probably 4 wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2 No 1 ☐ Yes 20/No 1 Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death | Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No

certificate be executed Box 68760, o Records, ivision of Vital To the Hospital or Attending I within 24 hours after death.
To the Funerei Director: After

has

certificate

this

After

completely filled in by

Medical

Baltimore, Maryland 21215-0036

is marked other then

Registrar

NWACHUKWU, MD

29c. License number

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Day, Year)

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nuachukwu

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Day, Year) MAY 2 3 State 3 2006

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Doris K. Williams 2006 May 18, 12:00 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1006 Markham Court, Apt. D Bel Air Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Yrs. 70 **Director** 215-32-6589 5, Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Iteme 23s or 28s-f show the Medical Examinar must be notified at Md. Harford Bel Air 1 ☐ Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1006 Markham Court, Apt. D 21014 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years homemaker own home permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Importent: If Item 27 is marked other any injury or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herbert R. Stevenson Ruth L. Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Doris P. Leader/daughter 446 Foreland Garth, Abingdon, Md. 21009 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gdns. 5/22/06 Bel Air, Md. 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tastat Luna Cancer Pnysician months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and Il-transit The law requires that the death certificate be executed Due to (or as a consequence of): physicien a s the burial-P.O. Box 68760, Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown ō Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 Ses 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 **X** No 1 ☐ Yes 2 ☐ No Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 0 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashkan Bahrani, M.D., 602 S. Atwood St., Suite 200, Bel Air, Md. 21014 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene [1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 05 19^{Day} 2006^{Year} **Physician** Robi Kay Wilding 11:54aм /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4231 Isbell St. Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) _ 50 6 Sex Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 🖾 F 212-68-3192 Yrs. Director 09-09-1955 Washington DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at MD Montgomery Silver Spring 1 ☐ Yes 2X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4231 Isbell St. 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Realtor Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Heelth and Mental H lant: If item 27 is marked out Be Alfred Snapp Mildred Holliday 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Vincent Wilding/husband 4231 Isbell St. Silver Spring MD 20906 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Chesapeake Crematory 05-23-2006 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral & Cremation Service M00382 tiples Humann 933 Gist Ave Silver Spring Md 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) 905et and Deaths Metastatic Lung Cancer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed burial-transit end Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physicien Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ After this certificate has been signifuneral director, page 2 should be 1 Tyes 2 No 3 Probably 4XXUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 🛭 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1x Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[I] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD46704 05-22-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 Merchantile Lane Largo MD 20774 Dr. Mutombo Kankonde 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 3 2006 Registrar

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) 33 PM Month Day Vear Physician Leonard Yankielunas 18 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 10 Zens Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number Date of Birth (Month, Day, Year) Days **Funeral** Min. Months Hours 1**X** M 2□ F 1915 Pennsylvania Director 195-09-1100 90 June 10. Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Exammet milital be notified at 1 XYes 2 No Director Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 415 Market Street 21078 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on tof Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Iter 1∭Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify 3 Widowed 4 □ Divorced WW II White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Home Builder Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Yankielunas (nmn) Stanley (nmn) Mary Chernefski ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If itam 27 ls any injury or othar trat once. 4 Oxford Court, Havre de Grace, Maryland 21078 Alan Yankolonis - Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Wilkes-barre, PA Oaklawn Cemetery 5/24/06 21. Signature of Fuheral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit attending physician and Due to (or as a consequence of): Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) the signed by t. d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 🗌 Yes 1 ☐ Yes a No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 No 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated-29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Remas completed cause of death (Item 23a) (Type, Print) 30. Name and address of person W DIONDO

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State Registrar 31. Date filed (Month Da

32 Registrar's Signature

			For State Registrar	State of	Maryland	-	rtment of H			giene 2	006	167	252	
	Physici	an	1. Decedent's Name (First, Middle, L THELMA A. YOU	-					2. Date of Dea	Day	Year 2006	3. Time of		
	/Medica Examine	er	4a. Facility Name (If not institution, g SINAi Hospital	- OF B	ALTIMOR		4b. City, Town, or BALT I	MORE (crty		nty of Death			
	Funeral Director		5. Social Security Number 6. 219-40-4438 Usual Residence of Decedent	Sex 1☐ M 2☐XF	7, Age (In yrs. I 62	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	7 Year) 1 1 9 4 3	Coun	lace (State of try) XYLANI	_	
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THELMA YOUNG 215-0036		by Funeral Director	11. Marital Status 1 🛣 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Dece Armed For 1 Tyes If Yes, Give Year or Da	θ		Vas Decedent of Hi f Yes, specify Cuba I □ Yes 2 🛣 No	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	В	ace - Americ lack, White, o cify: BLA	etc.		
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₹ ₽		To Be C	17. Father's Name (First, Middle, La MACK ROSEMO		,			MARG	me (First, Middle, ARET YO	UNG				
ZNOWN e, Maryla	and 2 should is salth and Men m 27 is markener traumatic		19a. Informant's Name/Relationship		HTER	201	g Address (Street a		OT #1,	GREEN	VILLE	, SC	9611	
<u> </u>	Page nent o ant: If		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 4 □ Donation 5 □ Other (Special Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control	cify)	CE CE	emetery, cren ETRO (sition (Name of natory or other plac CREMATOR	RY 5/2		CATON	SVILL	E, MC		
PATIENT Baltimo	permit. Departr Imports eny inju		21. Signature extruoreral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD 23a. Part. Enter the disease, or complications that caused the path. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between											
	Physician /Medical		23a. Pair Fore the disease, or co speck, or heart allure. List on Immediate Cause (Final disease or condition resulting in death)	a. SEP			er the mode of dyin	g, such as cardia	c or respiratory an	rest,		Approximate Interval Betwoonset and D	veen Death	
F	exacuted n and ial-transit	Examiner	Sequentially list conditions, it say leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(or as a consequence of):										
8760,	be		resulting in death) Last Due to (or as a consequence of): d.											
P.O. Box 6	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		irth 2∏Fetal ant at time of de	death 3	Ectopic pregnancy Other (specify)			1	ate of delive fonth	•	'ear	
	quires that in signed b uld be deta	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown				
al Reco	The ate h page	Completed							24a. Was a autop perfor	sv	death?	osy findings a npletion of ca 2 4 No	ivailable juse of	
Division of Vital Records,	To the Hospital or Attending Physicien: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 2 Accident investigat 3 Suicide 6 Could not	28a. Date of (Montil	of Injury h, Day Year)	ry Year) 28b. Time of 28c. Injury at Work? M 1 Yes 2 No				th (Check only one) ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,				
Div	Hospital or Att 24 hours after d Funeral Direct tely filled in by		3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									- 1		
	To the Howithin 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (M							, and due to	the cause(s)			
	->-0		MAY 17, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ruchi Puri Siwai Hospital of Bautimore						17,20	005				
ť	Sta	ate	Ruch Pur	Zi Sn	NAI Ho		OF BAUT	IMORE						
	Regist		MAY 2 3 2006	Liller 1/3-	18 M	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s								

		1- State of Maryland / Depa Registrar Cert	rtment of Health and Mo tificate of Death	ental Hygiene Reg. N	<u> </u>	16253
Phys		1. Decedent's Name (First, Middle, Last) Elizabeth J. Zwolinski		2. Date of Death Month Da May 19	ay 2006	3. Time of Death 8:10 P M
		4a. Facility Name (If not institution, give street and number) Franklin Woods Nursing Center 5. Social Security Number 6. Sex 1 \(\text{N} \) 1 \(\text{M} \) 83 Yrs.	4b. City, Town, or Location of Death Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	Baltimore	
D		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc		Jan. 15,		Od. Inside City Limits
e Mai	1	Florida Pineallas Tarpor	ı Springs			1 ☐ Yes 2 🕅 No
with the or 28	Director	10e. Street and Number 1258 Berkshire Lane	10f. Zip Code 34688		S.A.	try?
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland tal Hygiene. tal Hygiene. or litems 23e or 28e-f show ovent, I're Marice Espain afternative notified at	hy Firograf	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	/as Decedent of Hispanic Origin? (Sper Yes, specify Cuban, Mexican, Puerto F		14. Race - America Black, White, e Specify: Whit	etc.
C Z I Z I S-UUSB Hiled within 72 hours after Hygiene. Ther then "natural", or ite out, II & Musical Exercitiva	Completed		ent's Usual Occupation kind of work done during most of workin O NOT use retired)		Kind of Business/Ind	ustry
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arylar should by and Menta i marked umatic ey	F		Address (Street and Number or Rural		or Town, State, Zip	Code)
re, Maryles 1 and 2 should 1 Health and Meritam 27 Is marke other traumatic		Linda Gieseking (daughter) 1258	Berkshire Lane, T			
SAITIMORE, Dermit. Pages 1 a Department of Her mportent: If item eny injury or othe		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposicementary, crem			ocation - City or Tov	
ITIM it. Partmen rtent: njury		4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn 21. Signature of Eugeral Service Licensee 22.	Cemetery 5/25/2 Name and Address of Facility Sch		timore, M	
baltimore, permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other	Suce		705 Belair Rd., Bo			es
Pnysicia	an ·	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition	r the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
/Medic Examin		Due to kr a consequence of):	Irtery Dis	-2.01A		
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icate be executed physician and sthe burial-transit	me v	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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ecords, P.O. law requires that the de as been signed by the as 2 should be detached to	È	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		use contribute to the	
I HEC The law ate has b	, 8			24a. Was an autopsy performed?	prior to com death?	sy findings available apletion of cause of
Q9	TO BO	examiner?	26. Place of Death Other: 4 Wursing Hom	(Check only one) ne 5 Residence	6 □Other (Specify	,
r g inga	i			8d. Describe how inju		<u></u>
Dirtie C	Cortification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)		8f. Location (Street as City or Town, State	9)	
he Hospitel n 24 hours a he Funerel pletely filled	polical	29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death 2 **Medical Examiner: On the basis of examination and/or invariant and manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	nd due to the cause(s d at the time, date an	s) and manner as sta d place, and due to	ited. the cause(s)
To the within 2 To the complet	M	29b. Signature and little of certifier	29c. License number	29d. Da	ate signed (Month, E	ay, Year)
		Mr.	D5346 Z	- '	5/23/0	6
l		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Akwood Rd.	Glen Bu	mie me	21061
	State istra	31. Date filed (Month, Day, Year) MAY 2 3 2006 33 Registrar's Signature	di)			

			1 - For State Registrar		Maryland		artment of H			leg. No.	06	162	254
	Physici	an	Decedent's Name (First, Middle						2. Date of Dea Month	Day	Year	3. Time of	
4	/Medic	al	Irene D. 4a. Facility Name (If not institution	Zapata nive street and numb	er)		4b. City, Town, or	r Location of	May 17,	4c. County	of Death	5 a	1 "
	Examin	ier	3915 Setonhurst	-			Pikesvi				imore	2	
· ·	Funeral Director		5. Social Security Number 223–27–4254	6. Sex 7.	Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of Birth (Month, Day October 20	Year)	9. Birthi Cour Phi	olace (State o ntry) ippine	r Foreign
	death with the Maryland ms 23a or 28a-f ehow r mast be rediffed at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Balts	more		Town or Lo						0d. Inside Ci	·
	3a or 28a	Funeral Director	10e. Street and Number 3915 Setonhurst	Road			10f. Zip Code 21208			ited St			erica
	n 72 hours atter death with the Marylan "natural", or Items 23a or 28s-f show adical Exaction mist be notified at	þ	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Decede Armed Force ed 1 Tes 2 If Yes, Give Year or Date	∍s? XNo		Was Decedent of Hif Yes, specify Cuba	ispanic Orig an, Mexican, Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	Bla	ce - Americk, White,	etc.	
7-0-7 0-0-7	within 72 ho ene. then "natur	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4	or 5+)	(Give life. l	dent's Usual Occup kind of work done o DO NOT use retired	ation during most d)	of working	16b. Kind of B		dustry	
and 21	Hygi Hygi other	Be Con	17. Father's Name (First, Middle,	Last)		Нс	ome Maker		's Name (First, Middle,				
<u> </u>	2 should be and Mental is marked aumatic sv	은	Emilio Zapata						encia DePan				
e, Mar	りたいさ		19a. Informant's Name/Relations Greg Aragon	(Brot		754 E			Joppa, Ma		2108	35	
altimore	Pages 1 nent of H int: If Ite iry or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		CO	metery, crer	matory or other place ematory I:			Baltimo	•		nd
Dall	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service	Censee KOD	ner				Loring Bye Randallst				rs,I
116	Physician		Immediate Cause (Final disease or condition	complications that cau only one cause on eac	sed the death. h line.	Do not ent			cardiac or respiratory ari			Approximate Interval Bett Onset and I	e ween Death
	/Medical Examiner		resulting in death)	Due to (or	as a conseque		SWIAR	ARTE	VFARCTION 1405CLEROTIC	D156A	KE	1096A	RS
,00,	rate be executed thysician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseque	,							
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as, r	law requires that the death as been signed by the atter 2 should be deteched for u	by	Part II. Other significant condition	ns contributing to deal	h but not resul	Iting in the u	nderlying cause give	en in Part I.		bacco use cont	tribute to th	× /	eath? Inknown
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	an: Ti	0	25. Was case referred to medical	11401012 1	reurg	PAI	wha	26 Place	1 ☐ Yes of Death (Check only or	/3	1 🗌 Yes	2 No	
<u> </u>	Physician: this certific al director,	To B	examiner? 1 ☐ Yes 2★No	Hospital: 1 ☐ Inp	atient 2 🗆 E	R/Outpatien	nt 3 DOA Oth		sing Home 5 Resid		er (Specif	v)	
VISION OF	ding I		27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	ation	Injury Day Year)	28b. Time of Injury	Wor		28d. Describe h				
	tal or Attencis after death	Certification:	3 Suicide 6 Could i 4 Homicide determ	ined 286. Place of	Injury - At hor , etc. <i>(Specify)</i>	me, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rura	I Route Num	ber,
	To the Hospital or Attentwithin 24 hours after deating the Funaral Director: completely filled in by the	edicai	29a. Certifier Scertifyin (Check only one) 19 Certifyin 2 Medical	g Physician: To the be Examiner: On the basi and manne	is of examinati	vledge, death on and/or in	h occurred at the tin vestigation, in my o	ne, date and pinion, deatl	I place, and due to the conoccurred at the time, of	ause(s) and ma ate and place,	anner as s and due to	tated. the cause(s)
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2	′		30. Name and address of person RUBEN REIN	CR M.D.	7445		Print) NASE BI	RANCA	+ Rd 61en	Burni	e do	210	60
4	Sta	ite	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signati	ure							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

00		1- For State Registrar Certificate	of Death	, ,	g. No. 201	06 [62]
Physici ledical Exami		Decedent's Name (First, Middle, Last)		2. Date of Death Month May 3, 200	Day Year	3. Time of Death 1818 hrs
		Facility Name (if not institution, give street and number) 11008 Lombardy Road	4b. City, Town, or Location of Dea	ath	4c. County of Death Montgomery	
Funeral Director				8. Date of Birti	Foreig	nplace (State or New Jersey untry)
Aaryland 28a-f show any 1 at once.	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Maryland Montgomery Silver S 10e. Street and Number		I 10	g. Citizen of What Cour	10d. Inside City Limits 1 X Yes 2 No
the Mar 3a or 28	Director		20901		USA	uy r
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiens 77 is marked other than "natural", or items 23a or 28s-f she mustic event, the Medical Examiner must be notified at once	by Funeral	3 X Widowed 4 Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puel Yes 2 X No specify:	to Rican, etc.)	14 Race - Americ White, etc. Specify:	an Indian, Black. Thite
5036 Within 72 hours iene Ter than "natur. Medical Exami	Completed b		dent's Usual Occupation (Give kind of g most of working life. DO NOT use r		16b Kind of Business/li	
21215-0036 Juld be filed within 7 Mental Hygiene marked other than	Be	Hans Stegmeier	Ida R	me (First, Middle, Mehtang		
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Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and IN Important: If item 27 is m injury or other traumatic.		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: Ft. Linc	position (Name of cemetery, other place) oln Crematory 5	Date /6/2006	Brentwood,	
Balty permit Depar Impor		21. Signature of Funeral Sofvice Licensee.	2. Name and Address of Facility Ort Lincoln Fune 401 Rladensburg	ral Home Rd, Brent	wood, MD 2	20722
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a ASphyxia Due to (or as a consequence of):	er the mode of dying, such as cardiad	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
	7.	Sequentially list conditions, b				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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Box 68760, : death certificate be ex the attending physician ed for use as the burial	Physician/Medical		Fetal death 3 Ectopic preg	nancy	23d. Date of delivery Month D	ay Year
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Vita Physicia r this cer	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other,4 Nur	sing Home 5 F	Residence 6 🗸 Other:	Scene
Division of ' lal or Attending Ph rs after death al Director: After t led in by the funeral	Certification:		1 1 Yes 2 V No	Subject put p	ow injury occurred plastic bag over he	
Divis e Hospital or At 124 hours after d e Funeral Direc etely filled in by				or Town, Sta 11008 Lomb	ardy Road, Silver	Spring, MD
To the Hos within 24 h To the Fui	Medical	(Check only 1 Certifying Physician: To the best of my knowledge, death or one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated				
P S P S	Me	29b. Signature and little of certifier Clurch Haller	29c. License number O.C.M.E.		29d. Date signed (Mon May 4, 2006	th, Day, Year)
CR6)		n Street, Baltimore, MD 212	01		
S Regis	tate trar		le			
DHMH 17 Rev 172	2001	ORIGIN	NAL			

06-03216 Donald J. Britton

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		- For State Registrar		Cei	tificate c	t Dea	itn				eg. No.	fin w	/ U -	J 1 J 54 V
Physicia Wedical Examin	n/	Decedent's Name (First, Middle,I		ITTON			<u>.</u>		- 1 1	Date of Dea Month Nay 12, 2	Day	Year	3	3. Time of Death 2016 hrs
		DONALD 4a. Facility Name (if not institution,	give street and nu			_	, Town, or L	ocation of		,, .	4c. (County of I	Death	
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Funeral Director	- 1	010 00 0000	. Sex	7. Age (In yrs. I		Mon	ths Days	Hours	1 Adio		•	T _F	oreign	
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any		10a. State 10b. County		10c. City,	Town or Loca	ation		_						Od. Inside City Limits
ž .	١	Maryland Somers	set	¥	Ma:	rion	Stati	.on						1 Yes 2 X No
daryland 28a-f show 1 at once.	Director	10e. Street and Number		-		10f. Z	ip Code			1	0g. Citize	n of What		y?
with the Maryland ms 23a or 28a-f sho be notified at once		29762 Lovers Lar	ne e				21	.838				U.S.	Α.	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or items 23a or 28a-fishe or other traumatic event, the Medigal Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X Marr	1	cedent Ever in U. orces?			dent of Hisp cify Cuban,)- 1	4. Race - A		an Indian, Black,
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Iaut: If item 27 is marked other than "natural", or ite or other traumatic event, the Medical Examiner must	피		1 Yes	2 🔀 No		7 Van	2 X No	a na cifu				pecify:	Whi	. .
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	ğ	9			Wate	rman					Se	eafoc	d	
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121 I be fi ental arked	B	Richard Britton			40h Maili	A alala	ss (Street			ue Bu		T	01-1-	7:- O-d-)
D 2 should and M 7 is m	유	19a. Informant's Name/Relationshi Heather Marie 1		(Mife)		_	overs					,		21838
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygene. Important: If item 27 is marked other thingury or other traumatic event, the Mediumy or other traumatic event, the Mediumy or other traumatic event, the Medium or other traumatic event, the Medium or other traumatic event, the Medium or other traumatic event, the Medium or other traumatic event, the Medium or other traumatic event, the Medium or other traumatic event, the Medium or other traumatic event, the Medium or other traumatic event, the Medium or other traumatic event, the Medium or other traumatic event, the Medium or other traumatic event.	-	20a. Method of Disposition	STICCOII (20b.	Place of Disp	osition (N	ame of cem-			ate				own, State
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Balti permit Departm Importa		Robert H. Brads	1 . //	/	- 1	Brad	shaw 8 W. Mai	Son	s Fur	neral	Home	MD 2	181	7
Physician		23a. Part I. Enter the disease, or or failure. List only one cause of	omplications that of	caused the death									-	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease		ic (Heroir	and Fea	ntany.	l) into	xicati	ion					Death
CAdminer		or condition resulting in death)	Due to (or as	a consequence o	ारी)								Ĩ	
. "	-e	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of	of):								- 2	
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18760, rificate be ing physici as the buri.	Mec	IF FEMALE:		outcome of preg	nancy						23d	Date of de	elivery	
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P.O. Box 6 es that the death cer igned by the attendi		Part II. Other significant condition	ns contributing	to death but not i	esulting in the	underly	ing cause gi	ven in Par	rt I.	23e. Did t	obacco u	se contribu	ute to th	e cause of death?
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Divis Hospital or A 24 hours after Funeral Dire		4 Homicide 29a. Certifier 1 Certifying Phy	ysician: To the be		dge death occ	curred at	the time, dat	te and place				manner a	s starte	d.
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Ĭ Ā Š	Me	29b Signature and title of certifier					29c. License	number			29d. D	ate signed	(Mont	h, Day, Year)
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		30. Name and address of person v				n C+	et, Baltim	oro Mr	D 21201					
	o'r	Laron Locke MD. As	sistant Medic	ai Examiner Registrar's Signal		m Sue	ei, Daiiiii	IOIG, IVIL						
Regist	ate trar	MAY 2 3		19.5		mark.								

		•	For State Registrar	State	of Maryland		artment of H			giene L Reg. No.	006	16257
			1. Decedent's Name (First, Middle,	Last)					2. Date of De	_	20 Xear	3. Time of Death
	Physici /Medio	_	Joan C. Baker						May	0 ⁷	2006	0521 ^M
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	分表	18	Westminster Nurs 5. Social Security Number	Sing and	7. Age (In yrs. Ia		If Under 1 Year	ninster If Under 24 Hrs.	8. Date of Bir	th	Carro]	olace (State or Foreign
	Funeral Director		217-34-6904	1 ☐ M 2 🖫 F	69		Months Days	Hours Min.	(Month, Da	19, Year)	Cou	MD
14			Usual Residence of Decedent						1227			
	nylan how		10a. State 10b. County		10c. City,	, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	8e-f	Director	MD Carro	011		Wes	tminster			10 000		
	vith th	2	10e. Street and Number				10f. Zip Code	21157		iug. Citize	n of What Cou USA	ntry !
	eath ve 23.	erai	844 Snowfall V		cedent Ever in U.S	S. 13.			pecify Yes or No	p- 14	. Race - Ameri	can Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 Is marked other then "natural", or Iteme 23a or 28e-f show or other traumatic event, the Madical Examiner must be notified at	by Funerai	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed F	forces? 2 ⊡Xo iive		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐∰lo	Specify:	o Rican, etc.)	1	Black, White, pecify: Wh	etc. nite
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yla	2 should be filed within and Mental Hygiene. Is marked other than aurmatic event, the Ma	ျှ	John Geyer			401 10 11	A 1 1 (C)		Tooma		Ct-t- 7:	- 0- (-)
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 It any Injury or other tra QDCB:		Lynn Reeder/nic	ce	20b. Pl	ace of Dispo	4 Ivy Mil	OF /1	Reister 11/2006		tion - City or T	
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(*)	Pnysician /Medical Examiner	er	23a. Part1. Enter the disease, or of shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Due to	each line.	TIC ence of):	BREAST			ırrest,	,	Approximate Interval Batween Onset and Death
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COL	w requir	Completed							24a. Was		24b. Were aut	opsy findings available
Re	The lav	Ę.								psy ormed?	prior to co death? 1 ☐ Yes	empletion of cause of
tal		0	25. Was case referred to medical					26. Place of De	1 ☐ Yes ath (Check only	2 No	1 1 1 1 1 1 1 1 1	2 NO
	Physician: this certific ral director,	0	examiner? 1 🗆 Yes 2 No	Hospital: 1	Inpatient 2 🗆 l	ER/Outpatie	nt 3 DOA Oth	20	Home 5 Res		Other (Speci	fy)
0		n: T	27. Manner of Death	28a. Dat	e of Injury onth, Day Year)	28b. Time o	of 28c. Injun Wor	y at k?	28d. Describe	how injury	occurred	
Sior	ttendin death. ctor: Af / the fur	atic	2 Accident investig	ation				Yes 2 □ No				
Division of	or A Dire in by	Certification:	3 □ Surcide 6 □ Could n 4 □ Homicide determi	208. Fla	ce of Injury - At ho Iding, etc. (Specify	me, farm, st	reet, factory, office		28f. Location City or To	(Street and I own, State)	Number or Rur	al Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical E	xaminer: On the			th occurred at the time extigation, in my o	pinion, death occi		, date and p	lace, and due t	o the cause(s)
•	To the complet	Σ	29b. Signature and title of certifier	w K.	Galu	س آن	29c. Licens	31660	S	29d. Date :	Signed (Month)	Day, Year)
	104+4		30. Name and address of person values k.		use of death (Item	^{23а)} (Туре	Print) TUNEL	them.	e we	STM	U8/2	21157 MANYLANE
1		ate	31. Date filed (Month, Day, Year)	32.	Registrar's Signal	ture					<	-
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiené UU 5 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** TONETTE R. BURNQUIST 10:00 AM MAY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCESTER 23 EAST WIND DRIVE BERLIN | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MAR . 13, 1 Birthplace (State or Foreign Country)
 MN 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛛 F 74 Yrs. 476-32-0229 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28e-1 show any injury or other traumatic event, the Maryland Examinations to the result of the filed at any injury or other traumatic event, the Maryland Examinations. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo MARYLAND WORCESTER BERLIN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23 EAST WIND DRIVE 21811 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GROCERY CASHIER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ANTHONY REED CATHERINE MOUNT ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 EAST WIND DRIVE, BERLIN, MARYLAND 21811 ROWLAND J. BURNQUIST/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) CREMATORY OF DELMARVA 5/8/06 DELMAR, DELAWARE 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHOROSCUSCOTIC Physician MOIOVASCULAR /Medical Due to (or as a consequence of): **Examiner** PERTEUSION Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) signed by the a Id be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 1 Yes 2 No 1 Tyes 2 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only oper) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ို this : After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. within 24 hours after death.

To the Funeral Director: A completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely filled in the formal completely 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner estated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and alle of certifier 29c. License number 046257 8-2006

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10324 OLD OCEANCITY BLYD.

MAY 0 9 2006

31. Date filed (Month, Day, Year)

1300UN, M) 21811

EDWIN T. CASTANEDA, M.D.

ר

ROSCOE

TO PHYSICIAN: CLARK,

Maryland

Baltimore,

68760

Box

Records, P.O.

Division of Vital

NAME KNOWN

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Physician /Medical Examiner

the burial-transit as esn esn

that the death certificate be executed attending physician be detached for al or Attending F after death. I Director: After After

To the Hospital o within 24 hours aft To the Funeral Di State

31. Date filed (Month, Day, Year)

MAY 1 1 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene State of Junea b, per D, 638,82/16 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Yeer ROSCOE JACKSON CLARK РМ 4:40 MAY 06 2006 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) CECIL PERRY POINT VA MARYLAND HEALTH CARE SYSTEM If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1**X**M 2□F APRIL 6, 214-34-2340 68 1938 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 No MARYLAND CECIL ELKTON Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19 PINEHURST 21921 UNITED STATES Funera 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1956–60 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) VETERAN NAVY 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ROSCOE CLARK SARAH ELIZABETH ROBINSON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PHYLLIS L. CLARK / WIFE 19 PINEHURST, ELKTON, MARYLAND 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ST JAMES UNITED CEM. 5/13/06 HAVRE DE GRACE, MD ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 552 LEWIS STREET, HAVRE DE GRACE MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Chronic obstructive pulmonary disease linease or condition ANOXIC BRAIN INJURY Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) UNKNOWN Due to (or as a consequence of) Coronary Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 🗆 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ■Inpatient 2 □ ER/Outpatient 3 □ DOA 2 1 ☐ Yes 2 XNo 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier D52739 MAY 06, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH SHANDELYA, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902

DHMH 17 Rev 1/2001

Registrar

32 Registrar's Signature

16260

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23a or 28	Funeral Director	10e. Street and Number 95 Woodall Road			10f. Zip Code 21903			Og. Citizen of Wh United S		•	
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Faxed to ME.

			1 - For State of Maryland / Department	artment of Health and M rtificate of Death	R	eg. No. 0 0	6 16261
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	Day	3. Time of Death
1	/Medic	al	Victor D. Cross, Sr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May 8,	2006	7:00p M
	Examin	ier	Union Hospital	E1kton		Cec	
* \	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day)		9. Birthplace (State or Foreign
	Director		216-18-7864 1LXM 2LIF 80 Yrs.		November	2,1925	MD Country)
	yland now		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	e Maria	ctor	MD Cecil Elkto	n			1 ☐ Yes 2 X No
	vith th	Dire	10e. Street and Number	10f. Zip Code		0g. Citizen of W	
	ns 234	Funeral Director	111 Midland Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21921 Was Decedent of Hispanic Origin? (Sp.		U.S.A.	- American Indian,
0	after d	Fun	1 Never Married 2 Married 1X Yes 2 No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black	k, White, etc.
2	ural',	d by	3X Widowed 4 Divorced Year or Dates: 1940 S	1 ☐ Yes 2 ☐ No Specify:		Specify:	White
<u> </u>	n 72 h "nati	iete	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	16b. Kind of Bu	siness/Industry
7	d with giene. rr thar	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	hine Operator		Terum	no Medical Co
מום	al Hygal dothe	ВеС	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, I	Maiden Sumame	9)
<u>X</u>	Ment Ment Marke Marke	_C	John T. Cross		Vande		
2	d 2 st th and t7 fs n traun			ng Address <i>(Street and Number or Rura</i> ierce Rd., Risi			
ນົ	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Mudical Examination and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber and liber		20a. Method of Disposition 20b. Place of Dispo				21911 City or Town, State
	Page nent o ant: M ary or		1 Laburiai 2 Cremation 3 Removal from State		12,200	6 Elk	ton, MD
200	permit Pages 1 an Department of Heal Important: if Itam 2 any in ury or other once.		21. Signature of Fun. Licensee 22	Name and Address of Facility Andrew G. Gee F	uneral	Home	
1/2	00 % e 0			259 E. Main St.	. Elkt	on, MD	21921 Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	or the mode of dying, such as cardiac t	or respiratory arre	731,	Interval Between Onset and Death
	/Medical Examiner		resulting in death) a. Due to (or as a consequence of):				
	* *	-	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying b. Cus to (Jrs a co se uence of):	a.			Unk
	uted 1 Insit	Examiner	Cause (Disease or injury				
ĵ	an and rial-tra		that initiated events c. resulting in death) Last Due to (or as a consequence of):				
00/0	sate be executed oblysician and the burial-transit	lical	d				
Š K	ding p	/Med	IF FEMALE: 23b. We decoded program: 23c. If yes, outcome of pregnancy		_		
. DO	uires that the death certifics signed by the attending pt d be detached for use as t	Physiclan/M	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date Mon	of delivery th Day Year
Ė	that the ed by detact		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contri	bute to the cause of death?
ברים ברים ברים	w requires been sign should be	ted by				s 2 No	Phobably 4 Unknown
ני	ne law r has be ge 2 sh	Completed			24a. Was au autoas	y pr	Vere autopsy findings available for to completion of cause of
<u> </u>	n: The				1 Yes		eath? □ Yes 2 □ No
5	rsicial s certifirecto	o Be	25. Was case referred to medical examiner Hospital: 1 Inpatient FR/ utpatien	26. Place of Death			(C
5	ding Physician: The I h. After this certificate ha funeral director, page	-	'87 Marma of Death 28a. Date of Injury 28b. Time of		me 5 Reside 28d. Describe ho		
2	endin sath. or: Aff	atio	2 Accident investigation	M 1 Yes 2 No			
2 2	al or Attano s after death l Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (St. City or Town	eet and Numbe , State)	r or Rural Route Number,
	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the ca ed at the time, da	use(s) and man ite and place, ar	ner as stated. nd due to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	29c. License number	29	001	(Month, Day, Year)
} .	5 1 1 1/0		30 Name and sorress of person, who completed cause of death (Item 33a) (Type,	Print) 410 11 C	10		06
10	AIVA		1 Now Viran M)	18 North 87 r	est 87	e 313	CIKION
では	Sta Registr		31. Date filed (Month, Day, Year) MAY 1.: 0 2006 32. Philistrar's Signature	18 North 87 m		M	1) × (721,
DILL	MI 1 17 Day 1/04	204					

Registrar

State

DHMH 17 Rev 1/2001

Manoj Mathur, M.D.; 110 Hospital Road; Suite 305; Prince Frederick, Maryland 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 0 9 2006

			For State Registrar		State of M	_	partment of ertificate of		nd Mental Hy	giene Reg. No.2 0 0	6	16263
	Physicia		Decedent's Name (Fire	rst, Middle, Last)					2. Date of De Month		ear	3. Time of Death
	/Medic	al	Lillian 4a. Facility Name (If not				4b. City, Town,	ar Logation of	May_	6 20 4c. County of	006	8:45 A
	Examin	er	531 Fire				Colora		Death	Čec		
	Funeral		5. Social Security Number	er 6. Sex	7. A	ge (In yrs. last birtho		r If Under 24	Hrs. 8. Date of Bir Min. (Month, Da			ce (State or Foreign
	Director	-	219-28-6	727	M 2 🔀 F	89 Yrs	i. Moritina Bay	1100.5	11/27	7/1916	D	
	land		Usual Residence of Dec 10a. State 10b	o. County		10c. City, Town o	r Location				100	I. Inside City Limits
	Mary a-f sh	tor	MD (Cecil		Cecil	ton					Y Yes 2 No
	ith the	Direc	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	at Countr	y?
	s 23e	rai	168 Cent		ceet 12. Was Decedent	Ever in 11 S	2191		n2 (Specify Vos or No	USA - 14. Race -	American	Indian
10	fter de r ttem liner r	Funeral Director	 Marital Status Never Married 		Armed Forces 1 ☐ Yes 2	No			n? (Specify Yes or No Puerto Rican, etc.)	Black,	White, et	
21215-0036	within 72 hours after death with the Maryland ane. then "naturel", or items 23e or 28e-f show the Madical Examiner must be notified at	by	3X Widowed 4 □	Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	o Specify:		Specify:	Whi	te
5-0	"natu	Completed		Decedent's Educ nly highest grade		(0	ecedent's Usual Occi live kind of work don le. DO NOT use retir	e during most c	of working	16b. Kind of Busin	ness/Indu	stry
121	within ene. then the M	duic	Elementary/Secondary	y (0-12)	College (1-4or	5+)	ales Cle	*		Reta	il	
	a filed other vent,	BeC	17. Father's Name (First	t, Middle, Last)			4200 020		s Name (First, Middle,	21000		
Maryland	Menta Rarked arked	ToE	Alvah Ar						die Jane			
Mar	t 2 sho h and 7 Is m rraum		19a. Informant's Name/						or Rural Route Numb	anii aaanaanaaa		ode)
	1 and Healti iem 2	1 3	Bonnie I 20a. Method of Dispositi		//Daugn	20b. Place of D	isposition (Name of		Colora, N	1D 21917 20c. Location - Ci		n, State
10 m	Pages ent of ht: If it		1 XBurial 2 Cr		emoval from State)	crematory or other pi tephens		05/11/06	Earlev	i114	- MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Department of Health and Mental Hygiens Hygiens in protent: If item 27 is marked other then "natural", or flems 23e or 28e-f show any higher or other traumatic event, the Medical Examinar must be notified at any higher or other traumatic event, the Medical Examinar must be notified at any logice.	1	21. Signature of Eunera		99		22. Name and Add	ress of Facility				
<u> </u>	88 = 88	00	Sprin	Fella	NT.		370 W. C	ypres	s St. Mil	lington	MD	eral Home 21651
U			23a. Party Enter the di shock, or heart fail	lure. List only or	cations that cause ne cause of each	d the death. Do not line.	1			rrest,	1	Approximate Interval Between Onset and Death
	Pnysician /Medical	i i	Immediate Cause (Fina disease or condition resulting in death)	a a	July 8	a consequence of)	evative	Viso	rder		-	
В	Examiner				country (or a	/ / / / / / / / / / / / / / / / / / /						
	p #	iner	Sequentially list condition any, reading to immediate cause. Enter Underlying	g J	Due to (or a	ra nonecquanda of)						
	ecute and I-trans	Examiner	Cause (Disease or injur that initiated events resulting in death) Last	y	Due to (or a	a consequence of)						
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9	tificate ng phys as the	b	15 551111 5									
Вох	death certifica e attending ph d for use as th	an/N	IF FEMALE: 23b. Was decedent pre in the past 12 mon	gnant		2 Fetal death	3 □Ectopic pregnan	ncy		23d. Date of		ay Year
	he de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Pregnant a 9□ Unknown	at time of death	5 Other (specify)					,
P.O.	law requires that the de as been signed by the 2 2 should be detached 1	by Ph	Part II. Other significan	it conditions cor	tributing to death	but not resulting in the	ne underlying cause g	given in Part I.	23e. Did t	obacco use contribu	ute to the	cause of death?
ords	w require been sig should b		(0,19	estiv	'E //A	avt 1	allurg		1	Yes 2,⊠No 3	Probab	oly 4 □Unknown
Records,	has be	Completed	typeu	Hensi	dy				24a. Was	an 24b. We	re autops	y findings available pletion of cause of
al H	Th ate pag		Kjevi	holles,	10/01/01	119			1 ☐ Yes	20 No 1	Yes 2	□ No
Vital	Physicien: T this certificat ral director, pa	o Be	25. Was case referred t examiner? 1 ☐ Yes 2 ☑ No		lospital: 1 ☐ Inpat	ient 2 ☐ ER/Outp	atient 3 DOA	Whon	of Death (Check only of sing Home 52 Resi	77.5	(Snecifu)	
J of	ding Phy h. After this funeral c		27. Manner of Death	Pending	28a. Date of Inj	urv 28b. Tin	ie of 28c. Inj		-	how injury occurred		
sioi	Attending r death. sctor: After by the fune	catic	2 Accident	investigation			M 1	□Yes 2□No				
Division	after death Director:	Certification:	4 Homicide	determined	building, e	njury - At nome, farm tc. (Specify)	, street, factory, offic	8	City or To	Street and Number vn, State)	or Hurai i	Houte Number,
	To the Hospitel or I within 24 hours after To the Funerel Direct Completely filled in b								place, and due to the			
	the Ho the Fu the Fu	ledical	one)		and manner s				occurred at the time,			
	Vith To	Ž	29b. Signature and title	or certifier	. /1	11.	29c. Lice	nse number		29d. Date signed ()	vionin, Da	y, rear/
2			30. Name and address	of person who co	empleted cause of	death (Item 23a) (To	M // Cope, Print)	× > 9	/)	5-8	-0	P
U	me		WIII	1. Hiar	155	10.214	ELKH	M.N	10 2	1921		
	Sta	_	31. Date filed (Month, D			trar's Signature						
	Regist	ar		MAY 0 9	2006	Maries of	To ford	D				

DHMH 17 Rev 1/2001

		1- State of Maryland / Department of I Certificate of		al Hygier	211114	16264
q		Decedent's Name (First, Middle, Last)		ate of Death	Day Year	3. Time of Death
Physic /Medi		Anna Mae Clough	Ma		2006	1:28a ^M
Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town,	or Location of Death	-	4c. County of Death	
	5		ertown	1.000	Kent	(0)
Funeral		1 M M DE Months Days	Hours Min. (N	ate of Birth fonth, Day, Yea	ar) Country)	e (State or Foreign)
Director		212-12-7862 88 Yrs. Usual Residence of Decedent	06	/25/19	MD MD	
land ow		10a. State 10b. County 10c. City, Town or Location			10d.	Inside City Limits
Mary -1 ah	to	MD Queen Anne's Sudlersville				1 ☐ Yes 2 ☐ No
r 288	Director	10e. Street and Number 10f. Zip Code		10g. (Citizen of What Country	?
h witi	D E	541 Cemetery Road 2166	8		USA	
within 72 hours after death with the Maryland iene. r than "natural", or Items 23a or 28a-1 ahow the Medical Evaniner must be notified at	Funeral		Hispanic Origin? (Specify Yoan, Mexican, Puerto Rican		14. Race - American Black, White, etc.	
after or Ite		1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 ☒ No		,,		
iral',	d by	3 Widowed 4 □ Divorced Year or Dates:			0.5	
nat	Completed	15. Decedent's Education 16a. Decedent's Usual Occur (Specify only highest grade completed) (Give kind of work done life. DO NOT use retire	during most of working	16b.	Kind of Business/Indus	try
A IX IS DOUS aft ad within 72 hours aft giene. er than "natural", or the Medical Every	Ę,	Elementary/Secondary (0-12) College (1-4or 5+)	<i>30)</i>		TT	
0000		6 Homemaker 17. Father's Name (First, Middle, Last)	18. Mother's Name (Firs		wn Home len Sumame)	
e d la be	o Be	Medford Walls	Sadie Lu	ıff		
d 2 should by an and Menta 7 is marked traumatic every	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stree	1		y or Town, State, Zip Co	ode)
and 2 sauth ar n 27 ls		Linda Steigerwald/GDaughter 541 Cemete	ery RD Sud]	lersvi	lle MD 21	668
s 1 and 2 f Health item 27 other tra		20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place)	Date	_	Location - City or Town	
		1 X Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Sudlersville (1	/06 8	udlorevil	lo MD
injt		01 Cinneture of Euperal Contine Licenson	ace of Eacility			4
Per Per Per Per Per Per Per Per Per Per		Fellows	Helfenbei Cypress St. ing, such as cardiac or resp	in & N	ewnam Fun	eral Ho
ate be executed /Medical Examiner / physician and the burial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	seuse			
The COLOUS, F.C. DOX 00100, The law requires that the death certificate be executed as been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical I	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	ру		23d. Date of delivery Month Da	ıy Year
COTOS, P w requires that s been signed b s should be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	iven in Part I. 2	23e. Did tobacc	o use contribute to the d	cause of death?
quire quire en sig	Completed by	Multi interet Domentia		1 🗆 Yes	2€No 3☐Probabi	y 4 ∐Unknown
OI VITAL DECOLOS, Physician: The law requires triss certificate has been signeral director, page 2 should be tral director,	piet		2	24a. Was an autopsy	24b. Were autopsy prior to compl	findings available
The law	Eo		1	performed?	? death?	
ysician: The l ysician: The l is certificate ha director, page	a	25. Was case referred to medical	26. Place of Death (Che			
Ol VILA Physician: this certific	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	ther: 4 Nursing Home	5 🗌 Residence	6 □Other (Specify)	
ff and and and and and and and and and and	ation:	27. Mann f of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury William of Injury M 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ory at 28d. □ ork? □Yes 2 □ No	Describe how in	ijury occurred	
DIVISION al or Attending s after death. Il Director: Afte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. L	ocation (Street City or Town, Sta	a <i>nd Number or Rural R</i> ate)	oute Number,
To the Hospital or within 24 hours after To the Funeral Direction Completely filled in I	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contr				
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		P MULL DS	18824		5/07/	06
) ms		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Donaher 119 C North Main St. Gall	The second second	635	. 0	
S	tate	31. Date filed (Month, Day, Year) 32. Registre's Signature	- C.I.U. 21			
Regis		MAY 0 9 2006	ġ.			

			State of Maryland / Departr	ment of Health and Micate of Death		ZHHb	16265
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medi		Frank Charles Conte		May 16	,2006	3:36 M
	Examir			. City, Town, or Location of Death		4c. County of Dealh	
				Frederick Under 1 Year If Under 24 Hrs.		Freder	
	Funeral		113tM 2□E	Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Ye		place (State or Foreign htry)
	Director		0 9 0 - 1 4 - 8 6 8 6 8 6 8 6 8 6 8 6 8 6 8 6 8 6 8		2/10/19	920 N.	Υ •
	yland		10a. State 10b. County 10c. City, Town or Location	on		1	0d. Inside City Limits
	Mar	ţŏ	MD Frederick Frederick				1 ☐ Yeş 2 X No
	or 28	ire	10e. Street and Number	Of, Zip Code	10g.	Citizen of What Cour	ntry?
	Ifh wi	ai	10030 Gas House Pike	21701		USA	
	within 72 hours atter death with the Maryland ene. then "naturet", or items 23s or 28s-f show the Medical Exercities must be notified at	Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 13. Was	Decedent of Hispanic Origin? (Spe s, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	or it	Z.	1 Never Married 2 Married 1 X Yes 2 No	Yes 21 No Specify:		Specific	
Ö	ture	pa pa	42-40	s Usual Occupation	166	. Kind of Business/Inc	hite
21215-0036	in 72	Siet	(Specify only highest grade completed) (Give kind	of work done during most of worki NOT use retired)	ng 160	. Kind of business/in	oustry
212	iene i	E	Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Labora	torv Technici	an St	tate of V	Virginia .
	othe othe	O	17. Father's Name (First, Middle, Last)	*	(First, Middle, Maid		- 0,
lar	Aenta Menta	To Be	Joseph Paul Conte	Marie	Nelson		
Maryland	d 2 should be filed within ? h and Mental Hygiene. 7 is marked other then "r treumatic event, I.a Med	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad	idress (Street and Number or Rura	I Route Number, Cit	ty or Town, State, Zip	Code)
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Heatih and Mental Hygiene. Item 27 is marked other then "naturel", or items 23a or 28a-f show then treumatic event, its Medical Examinar must be notified at		Helen Hodges Conte Wife 10030	Gas House Pik	e Freder	rick MD 2	21701".
Baltimore,	of Heror		20a. Method of Disposition 1 ☐ Burial 2 [X]Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cremator.	n (Name of Cry or other place)	Pate 20c	. Location - City or To	own, State
Ĕ	permit. Pages Department of t Important: If ite any injury or of		4 □Donation 5 □Other (Specify) Smithsburg	g Crem. 5/18	3/2006Sm	ithsburg	, MD
Salt	Depart Depart Import any inj ance.		21. Signature of Funeral Pervice Upensee 22. Na	me and Address of Facility Ke	eney & E	Basford I	P.A. F.H.
_	<u>80</u>		 	East CHurch		rederick	k MD 21701
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the prock, or heert failure. List only one cause on each line.	e mode of dying, such as cardiac of	r respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	nd to He	ad		Nigutes
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
		<u></u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				· · · · · · · · · · · · · · · · · · ·
	bet	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events constitution of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition				
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760,	sicier buri	ical E					
687	eath certificate be executed ettending physicien end for use as the burial-transit		0.				
Вох	Physician: The law requires that the death certifica this certificate hes been signed by the ettending phiral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ory
ω.	deatl	icia	1 Ves 2 No. 4 Pregnant at time of death 5 Oth	opic pregnancy ner (specify)		Month	Day Year
P.0	w requires that the death cer been signed by the ettendin should be detached for use	hys	9 Unknown				
S,	gned gned be de		Part II. Other significant conditions contributing to death but not resulting in the under	ying cause given in Part I.	23e. Did tobacc	o use contribute to th	e cause of death?
ord	equir en si ould i	be	Depress 104		1 🗆 Yes	2 No 3 □ Prob	ably 4 □Unknown
Records,	hes be	pie			24a. Was an autopsy	24b. Were autop	psy findings available
<u> </u>	The ate h page	Completed by			performed	? death?	2 No
Vital	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Be (25. Was case referred to medical exagginer?	26. Place of Death	Account to the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s		
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	ing P	Certification:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day/Year) Injury	Work?	28d. Describe how in	171 1	c 10
Sio	Attending r death.	cat	2 Accident investigation 5/6/06 3:36 Am 3 Suicide 6 Could not be		subject	Shot	. /
Division	or At or At Direct in by	i i	38 Suicide 6 Could not be determined 286. Place of Injury - At home, farm, street, building, etc. (Specify)	actory, office	City or Town, St	and Number or Rura	Route Number
	pital orei l		29a. Certifier J Certifying Physician: To the best of my knowledge, death occ		Freder	CK, MD	21701
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edicai	29a. Certifier (Check out) One) Certifying Physician: To the best of my knowledge, death occ (Check out) Medical Examiner: On the basis of examination and/or investig and manner stated.	gation, in my opinion, death occurre	ed at the time, date a	and place, and due to	ated. the cause(s)
	omple omple	Me	29b. Signature and little of certifier	29c. License number	29d. I	Date signed (Month, I	Day, Year)
	- 5 - 0		> Colon Police MDI DIME	207407	N	2.17	2001
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print	D37197	1///	ay 11,	2006
				venth Street	Frederic	k MD 21	701
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Regist	ar	MAY 2 3 2006 A & Ages	Es			
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			For State Registrar			of Mary	land	-			ealth a	and M	lental Hyg	Reg. No.	06	162	266
	Physici /Medio Examir	al	Decedent's Name (Fi Ronald Aa. Facility Name (If not)			umber)	Doi	rman	4b. City,	Town, or	Location of	of Death	May 13		Year y of Death	3. Time of 7:15	
	Funeral		14605 Vie 5. Social Security Numb	er 6.	Road S	7. Age (In		t birthday) Yrs.		nber 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	Alleg	-	place (State o	or Foreign
	Director work	_	286-26-18 Usual Residence of Dec 10a. State MD				c. City, T	Fown or Lo		nd			OCI 10	, 1932		0d. Inside Ci	
	with the Ma a or 28a-f	Directo	10e. Street and Number			SW SW			10f. Zip	Code	21502	2		10g. Citizen of	What Cour	1 🗆 🗶es	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f show important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be rotified at ance.	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4	2 Married	12. Was De	ecedent Ever Forces? s 2 No Sive	r in U.S.		Was Dece Yes, spe	dent of Hi cify Cubai			ecify Yes or No- Rican, etc.)	14. Ra Bla	ce - Americ ck, White,	etc.	
Baltimore, Maryland 21215-0036	ed within 72 horygiene.	Be Completed	(Specify of Elementary/Secondary 12	y (0·12)	rade complete	d) (1-4or 5+)		16a. Deced (Give life. L	kind of wo	rk done d se retired,	luring mosi)			16b. Kind of E	usines		S.
ryland	hould be fill d Mental Hy narked oth	To Be	17. Father's Name (First Dallas V	V. Dori	man			10h Mailin	a Address	/Street	Arti	e (E	First, Middle, Prooks) [Dorman		Cada	
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Itimor	nit. Pages artment of ortant; If it injury or o		1 Burial 2 Ci 4 Donation 5 C 21. Signature of Funera	remation 3 Other (Spec	cify)	m State		ary's C	emete	ery	‡ ‡		5/18/2006 ome, P.A.				MD
B	Dep imp		23a. Part1. Enter the d shock, or heart fai	isease, or co	mplications that	t caused the	death.	(10	8 Virg	inia A	/enue	e; Cumber		21502	Approximat Interval Bet	e ween
8760, <	by Sician and Examine the percentage of attending physician and a strength of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the percentage of the pe	licai Examiner	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition if any, leading to immediate, leading to immediate cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last	ons, diate g	b	o (or as a co	onsequer	nce of):	Cer	pleu	ક ૧૪ન		Effe	pas		Onset and I	ants
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	law requires that the as been signed by th 2 should be detache	۵	Part II. Other significan	nt conditions	contributing to	death but no	ot resultin	ng in the ur	nderlying o	ause give	en in Part I.		101		3 🗆 Prob	pably 💆	Jnknown
tal Rec	w 200	e Completed	25. Was case referred	to medical							26 Place	of Death		med? 2. No	prior to co death?	psy findings mpletion of c 2 No	available ause of
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours eiter death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	To B	examiner? 1 Tes 2 No 27. Manner of Death	☐ Pending investigat	28a. Da: (M	☐ Inpatient te of Injury onth, Day Ye	28	VOutpatien 3b. Time of Injury		28c. Injury Work	9r: 4 ☐ Nu	rsing Ho	me 5 Resid	lence 6 □Oti		y)	
Divis	ital or Atterns efter de rel Directo	Certification;	4 Homicide	Could not determine	ed 280. Pla	ce of Injury - Iding, etc. (S	Specify)						28f. Location (5 City or Том	m, State)			ber,
	the Hospital hin 24 hours the Funerel hpletely filled	ledical	(Check only 2 one)	Medical Ex	aminer: On the	he best of m basis of exa anner stated.	y knowle amination	edge, death n and/or inv	estigation	, in my op	oinion, dea	d place, th occurr	and due to the dead at the time, of	date and place,	and due to	the cause(s	·)
	To To Com	Σ	29b. Signature and title	1- We	ue d	2	//4	201/7		c. License	0060	478		May	15 ₁	ay, Year)	6-
	10 Sta	ate.	Afaq Ahn 31. Date filed (Month, D	nad M	.D.			625 k	ent A	venu	ue Cu	ımbe	erland M	D 21502	2		
	Regist		MAY	2 3 20	006	Registrar's	A.	Goe	()								

	n	1. Decedent's Name (First, Middle, La ROBERT TOWNSE:		OOD, SR	•			2. Date MAY		06 Yeer	3. Time of Death 21:00 P M
/Medica Examine		4a. Facility Name (If not institution, giv	e street and number	er)	4b	. City, Town, or		Death		tc. County of Dea	
uneral rector			Sex 7 1 ☑ M 2 ☐ F	Age (In yrs. last i 94		Under 1 Year onths Days	If Under 24 Hours	Min. (Mont	of Birth n, <i>Day</i> , Yea EMBER	9. Bir 1,1911	thplace (State or Foreig ountry) MD
in paid		10a. State 10b. County MD QUEEN A	NNE'S	10c. City, To	own or Location	ertown	-				10d. Inside City Limits 1 ☐ Yes 2∑ No
e or 28	ੂ ∣	10e. Street and Number 213 FEY ROAD			1	0f. Zip Code 21620				Citizen of What Co	ountry?
of, or Itams 23	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tyes 25 If Yes, Give Year or Date	s? ∑No	If Yes	Decedent of H	an, Mexican, F	n? (Specify Yes Puerto Rican, etc	or No-	14. Race - Ame Black, Whi	te, etc.
than "neture The Madical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)			(Give kind life. DO f	s Usual Occup of work done o NOT use retired ANCE BR	during most o d)	f working		Kind of Business	
ked other	To Be C	17. Father's Name (First, Middle, Last ISSACC ROBERT)		WOOD				Name (First, M LIZABET			
i. Pages 1 and 2 she frient of Health and rtant: If itam 27 is m jury or other traum		19a. Informant's Name/Relationship (RICHARD C. FLEET)		1				or Rural Route A TERTOWN		y or Town, State, . 21620	Zip Code)
	20a. Method of Disposition 1 Ma Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci		te cr ceme	of Disposition tery, cremato	n (Name of ry or other place CEMETE! Cenete :	ce)	Date 05/09/	C	Location - City or hesterto	wn.MD	
Imports any inju once.		21. Signature of Funeral Service Lice	Nelfen	bein	22. Na FEI	me and Addres	ss of Facility HELFEN	BEIN AN	O NEWI	NAM FUEN MD 216	RAL HOME,
The law requires that the death certificate be executed by the attending physician and be detached for use as the burial-transit completed by Physician/Medical Examiner		Immediate Cause (Final disease or condition	a CARD					rdiac or respirat			Interval Between Onset and Death
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or o	if ite		20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place of cemeter	f Dispos ry, crem	ition (Name of atory or other place		Date	20c. Location	- City or To	own, State
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B	permit. Pages 1. Department of He Important: If Iten any injury or oth once.		9/B. A	al mo	1247				HOME, SEI	BYVILLI	E. DEI	LAWARE 1997
			23a. Part1. Enter the disease, or co shock, or heart failure. List of	problications that caused	the death. Do							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				INTEN					Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):		10:00				
		ē	Sequentially list conditions,	b. Due to for as	a consequence	of):						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to initiative cause. Enter Underlying Cause (Disease or injury that initiated events	,		. .,.						
.09	s be executed sician and burial-transit		resulting in death) Last	c. Due to (or as	a consequence	of):						
000	ate be hysici the bu	licai		d.								
) X X X X X X X X X X X X X X X X X X X	n certific anding pl use as t	/Med	IF FEMALE:	23c. If yes, outcome	of programmy					- 12		
Bo	leath certifi attending 1 for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregnancy Other (specify)	,			ate of delive onth	ry Day Year
10 0	that the death	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			(0,000,1)					
S. P	The law requires that the death certificate be executed to the been signed by the attending physician and rage 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions	contributing to death be	ut not resulting in	n the und	derlying cause giv	en in Part I.	23e. Did t		tribute to th	e cause of death?
FR MN KIII SSB O tal Records,	requir	Completed							_ 10'	Yes 2.ETNo	3 🗌 Prob	ably 4 □Unknown
Sec 3	ne law hes b	mple							24a. Was	osy	prior to cor	osy findings available appletion of cause of
a 50 E	n: Th ficate or. pag	e Co	25. Was case referred to medical	(max-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1					1 ☐ Yes		death?	2 🗆 No
7 7	Physician: this certific ral director,	To Be	examiner? 1 \sum Yes 2 \sum No	Hospital:	nt 2 PER/Ou	toatient	3 DOA Oth		Death Check only of Home 5 Resid		(C	
2 % 10	ng Phi ter thi	n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry 28b. T	Time of	28c. Injur			now injury occur		"
Sion	ttending death. stor: After the fune	catic	2 Accident investigat 3 Suicide 6 Could not	ion ho			M 1 🗆	Yes 2 □ No				
Medf 222 222 Division	or At after d Direct in by	Certification:	4 Homicide determine		ury - At home, fai c. <i>(Specify)</i>	rm, stree	et, factory, office		28f. Location (S City or Tox	Street and Numi vn, State)	ber or Rura	l Route Number,
8	Hospitei 4 hours a Funerel tely filled	al Ce	29a. Certifier 1 Certifying	Physician: To the best of	of my knowledge	, death	occurred at the tin	ne date and pla	ice, and due to the	cause(s) and m	200001 25 55	atad
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director. page	edical	(Check only 2 Medical Ex	aminer: On the basis of and manner sta	examination and	d/or inve	stigation, in my o	pinion, death oc	curred at the time,	date and place,	and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier)			29c. Licensi			29d. Date signe		
	13		1 phil				0	3835	3	5-	8-2	006
	Xa		30. Name and address of person wh	o completed cause of de	eath (Item 23a) (Type, P	rint)	. 17 /	3 ve #402	6 ,	. "	121611
4	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	. 3	14 FRAN	IKIIn A	ve 402	DER/11	1 ///c	13/5//
	Registr	ar	MAY 0 9	2006 June	in the	1	ande					

			State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State of The State	artment of Health and Natificate of Death	lental Hyg	iene	06	152	69
			Decedent's Name (First, Middle, Last)		2. Date of Deat	h		3. Time of	Death
	Physicia /Medic		Michael Graig		Month May	Day 4	2006	1:15	РМ
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. Coun	ty of Death		
	4		Anne Arundel Medical Center	Annapolis		Anne	Arund	e1	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 050-26-1932 15 M 2 F 73 Yrs.	If Under 1 Year 3f Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Dec. 22,	^{Year)} 1932	9. Birthp Coun New	lace (State o itry) York	r Foreign
	tand		10a. State 10b. County 10c. City, Town or Lo	cation			1	0d. Inside Ci	ty Limits
	Many f sh	ţō	Maryland Anne Arundel Ann	apolis				1 🗌 Yes	2 🕅 No
	r 28a	Funeral Director	10e. Street and Number	10f. Zip Code	10	Og. Citizen o	f What Cour	itry?	
	h witi	a D	1527 Gordon Cove Drive	21403	U	nited	State	s	
	ems ems	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Vamed Forces?	Nas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ		
õ	or It		1 ☐ Never Married 2 ☒ Married 1 ☒ Yes 2 ☐ No 1950 —	I ☐ Yes 2 🖾 No Specify:	, ,	Spec	7.74	ite	
3	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Modeal Exercited is unit to mailled at	d by	3 Widowed 4 Divorced Year or Dates: 1955	tente Herrel Occurration				4	
5	n 72	lete	(Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	16b. Kind of	Business/inc	dustry	
21212-0030	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or Items 23a or 28a-f show avant, it s Marical Examine in unit be natified at	ompleted	Elementary/Secondary (0-12) College (1-4or 5+)	ales & Marketing		Self	Emplo	ved	
-	filled Hygi othar ant,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, N			,	
/land	should be nd Mental markad o imatic ava	To B	Alfonso Garguilo	Josephin	e DeMarc	0			
	2 should and Men is marka aumatic	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	g Address (Street and Number or Rur	al Route Number,	City or Town	n, State, Zip	Code)	
ĭ Z	1 and 2 Health a tem 27 is		Winifred B. Graig / Spouse 1527	Gordon Cove Drive	Annapol	is, Ma	rylan	d 2140	13
ore,	es 1 and of Health f item 27 r other tr		20a. Method of Disposition 20b. Place of Dispo	sition (Name of natory or other place)	Date 2	20c. Location	- City or To	wn, State	
Ĕ	Pages nent of ant: If it ury or o		'4 □Donation 5 □ Other (Specify) Lakemont	Mem. Gardens 5/10					
Baitimor	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marka any injury or other traumatic once.			Name and Address of Facility Jo. 147 Duke of Glouc					
/bu,	w requires that the death certificate be executed We require that the death certificate be executed Should be detached for use as the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not entershock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		-			Interval Bett	veen Death
O. Box 68	the death certifica y the attending ph iched for use as th	Physician/Med		Ectopic pregnancy Other (specify)			eate of delive	-	'ear
ds, r	requires that the een signed by the	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tob 1 ☐ Ye	acco use con	ntribute to th 3 Prob		eath?
Hecord	e la has le 2	Completed			24a. Was ar autopsy perform 1 Yes 2	ned?	. Were autoperior to condeath?	osy findings and pletion of ca	available ause of
VII	ysician: This certificate director, pag	Be	25. Was case referred to medical examiner?	26. Place of Deat					
_	sit din	10	1 ☐ Yes 2☑ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatien		me 5 Resider	nce 6 🗆 Ot	ther (Specify	′)	
Ē	ding Phy th. After thi funeral	on:	27. Manner → Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe hor	w injury occu	ırred		
VISION	tand death tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	206 Leasting (Cts			/ D- 11 4/ 11	
<u> </u>	after of Direction by	ertification:	4 Homicide determined 28e. Place of Injury - At home, farm, strubulding, etc. (Specify)	eet, ractory, onice	28f. Location (Str City or Town,		iber or Hura	i rioute Numi	oer,
	To the Hospital or Attanding PP within 24 hours atter death. To the Funeral Director: After it completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death one investigation and/or investigation and manner stated.	n occurred at the time, date and place, restigation, in my opinion, death occur	and due to the ca red at the time, da	use(s) and nate and place	nanner as st	ated. the cause(s)	
	To th withir To th comp	Me	29b, Signature and title of entifier	29c. License number		d. Date sign			
	<		49	D00058297	3	-5	-20	06	
			30 Name and address of person who completed cause of death (Item 23a) (Type, D. Yonn & MD Anne Arandel Me	Print) 2001 Medical Dick Center, Av	PArkway	MD ?	2140	(
	Sta Registr		31. Date filed (Month, Day, Year) 32 negistrar's Signature 0 8 2006	and a					

			1 - For State Registrar	State of Maryland		artment of He tificate of D			iene _{99. No.} 2 0 0 6	16270
	Physici	an	Decedent's Name (First, Middle, Last) Frances Marie Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater Greater G	eenstreet				2. Date of Deat Month May	3, Day 2006	3. Time of Death 5:30 a M
)	/Medio Examin		4a. Facility Name (If not institution, give s 455 Ruth Road 5. Social Security Number 6. Sex	7. Age (In yrs. la	**	4b. City, Town, or I	Location of Death nold If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jul. 12	4c. County of Death	Arundel place (State or Foreign untry)
	Director		216–28–5411 Usual Residence of Decedent 10a. State 10b. County	M 2XF 73	Yrs. Town or Lo			Jùl. 12	, 1932	VA 10d. Inside City Limits
	the Maryi 28e-faho acilijeda	Director	MD Anne Ar	undel		Arno	ld	10	og. Citizen of What Co	1 ☐ Yes 2 🔀 No
;	sain with	Funeral Di	455 Ruth Road	2. Was Decedent Ever in U.S	13.1	21	012	ecify Yes or No-	USA	ican Indian.
220	ours after or real', or item Exemilier	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2 🛱 No	, Mexican, Puerto Specify:		Black, White Specify: W	hite
Maryland 21213-0036	permit. Pages 1 and 2 should be lited within 72 nouts after death with the maryland Department of Health and Mental Hygiene. Important: if term 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Mexical Exemitier main be notified at ODGE.	Completed	15. Decedent's Educ (Specify only highest grade Efementary/Secondary (0-12) 12		(Give	dent's Usual Occupa kind of work done di DO NOT use retired) Secretar	uring most of work	ing	ER — Balti Washingtor	
ומומ	uid be file Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) Frank Tolley				18. Mother's Name Retha Ca		Maiden Sumame)	
Mary	and 2 shou alth and N 27 is ma er treums		19a. Informant's Name/Relationship (Type Kimberly Butler/D			ng Address (Street a			City or Town, State, Z 21012	ip Code)
altimore,	Pages 1 a ment of He ant: if Itam ury or othe		20a. Method of Disposition 1 ☐ Burial 2 反 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	metery, crer	sition <i>(Name of</i> natory or other place ematory	May h	4.	Baltimore,	
Balt	Departi Departi Importi any inj		21. Signature of uperal Service License	Allen	В	Name and Address arranco & 95 Gov. R	Sons, P.	A. Seve	rna Park Fu rna Park, M	neral Home ID 21146
,	Physician and Medical Examiner the private transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit tr	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a conse	ence of):	er the mode of dying	, such as cardiac (or respiratory arre		Approximate Interval Between Onset and Death
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ָר י ה	quires tha n signed l uld be det	þ	Part If. Other significant conditions cor	tributing to death but not resu	lting in the u	nderlying cause give	n in Part I.		acco use contribute to s 2 □ No 3 □ Pro	the cause of death?
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sion :	To the Hospitel or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this centificate hes completely filled in by the funeral director. page 2	Certification: To Be	27. Manner of Death 1 Maturaf 2 Accident 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28e. Pface of Injury - At hor	ER/Outpatien 28b. Time of Injury	ott 3 DOA Other	at ?	me 5 Reside 28d. Describe ho 28f. Location (Str	nce 6 Other (Spec w injury occurred	
5	ospitel or hours after ineral Dire y filled in b	al Certi	25a Cerifler 1 Certifying Phys	building, etc. (Specify,	nedys, death	occurred at the time	a, date and plane.	City or Town	uso(s) and manner as	stated.
)	To the Hospital or At within 24 hours atter To the Funeral Direct completely filled in by	Medical	29b. Signature and title of certifier 30. Name and address of person who co	mpleted cause of death (ftem 305 l	on and/or in	29c. License	number	ed at the time, da	nte and place, and due	to the cause(s) Day, Year) O O 6
8	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 9 20	32 Aegistrar's Signat	10201	tal Di	re gle	n Islam	me, MD	21061

			1 - For AMEND#29D per Phy State Registrar AACO HEALTH D	State of Marylar PT 5/8/06 CMH	nd / Depa <i>Ce</i> a	artment of <i>rtificate o</i>	Health an f Death		iene _{99. No.} 2 () (16271
	7)		1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month		3. Time of Death
	Physici /Medic		Bernard	Green					2006	7:30 A M
	Examin	er	4a. Facility Name (If not institution, give				, or Location of D	Death	4c. County o	
			922 Shipmaster Co		last highday)		apolis	Hrs. 8. Date of Birth		Arundel
	Funeral Director			x 7. Age (my/s. 77	Yrs.	Months Day		Min. (Month, Day,		9. Birthplace (State or Foreign Country)
			Usual Residence of Decedent					May 17	, 1920 IN	Maryland
vlan	how		10a. State 10b. County		ty, Town or Lo	ocation				10d, Inside City Limits
Ma Ma	Ba-f a	Director	-	Arundel Ar	napo]					1 ☐ Yes 2 X No
with th	be n	2	10e. Street and Number	a .		10f. Zip Code	° 2140		0g. Citizen of W	nat Country?
aath	9 23g	era.	922 Shipmaster	12. Was Decedent Ever in U	S 12	Was Decedent of		? (Specify Yes or No-	USA 14 Bace	- American Indian,
ftard	F and	Funeral	1 □ Never Married 2 Married	Armed Forces? 1 May Yes 2 □ No WW		If Yes, specify C	uban, Mexican, P	Puerto Rican, etc.)		, White, etc.
	0 1	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: Kore	ea	1 □ Yes 2 ∏ N	lo Specify:		Specify:	White
G Z I Z I 3-U030 filed within 72 hours after death with the Maryland	natu	Completed	15. Decedent's Edu (Specify only highest grad	ucation	16a. Dece	dent's Usual Oct	ne during most of	f working	16b. Kind of Bus	iness/Industry
	han w	Ig III	Elementary/Secondary (0-12)	College (1-4or 5+)		Denuty		for Managem	nent Fe	deral Gov't.
N P	Hygie ther t nt, th		12th - 17. Father's Name (First, Middle, Last)	4 years	7100 0	Depacy		Name (First, Middle, I		
= 8	ental c ev	o Be	Harry H. Green					la Lynch		,
ar y la	if Haalth and Mental Hygiena. Item 27 is marked other than "natural", or Iteme 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ဥ	19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Maili	ng Address (Stre	et and Number o	or Rural Route Number	, City or Town, S	itate, Zip Code)
and 2	m 27 is mer trac		Adele M. Green/ W	ife	922 \$	Shipmast	er Ct. A	Annapolis,N	1D.21401	
u	of Ha		20a. Method of Disposition		Place of Dispo cemetery, crea	osition (Name of matory or other p	p/ace)	Date	20c. Location - C	City or Town, State
ALLINOT THIL Pages	ant: If		1 № Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)	MD			etery 5,		rownsvi	•
	Dapartmant of the Important: If ite any injury or of once.		21. Signature of Funeral Service License	88	22	2. Name and Add	dress of Facility (George P. I	Kalas Fu	neral Home
ď	05 = 9		JR . Kali	n//)	2	973 Solo	omons Is	land Rd. Ed	dgewater	, MD 21037
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	nle/cause on each line.					est,	Approximate Interval Between Onset and Death
	nysician Medical		disease or condition resulting in death)	a MyD	card	jal 1	ntare	tron		
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Ε.		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consec	uence of):					
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Ç ağ	cian a purial-	EX	resulting in death) Last	Due to (or as a consec	juence of):					
cata ba ay	physic that	dical		d						
	baan signad by tha attanding p should ba datachad for usa as	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregna	ancy				23d Date	of delivery
	affor t	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		□Ectopic pregna □ Other (specify)			Mont	,
j <u>a</u>	by the achac	hysi	9 Unknown	9□ Unknown						
The law recovines that the death	gnad sa dat	oy P	Part II. Dther significant conditions co	ntributing to death but not res	sulting in the u	inderlying cause	given in Part I.	23e. Did tob	acco use contrit	bute to the cause of death?
aw racuiras	an sign	ed	Dabetes mi	2 Litus Hy	pert	enslow	1	1Ye	s 2□No 3	3 ☐ Probably 4 Æ Unknown
	as ba	Completed by	Cormayo	intery disc	456			24a. Was a autops	n 24b. W	ere autopsy findings available for to completion of cause of
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DIVISION For Attending	octor.	ertification:	3 Suicide 6 Could not be	286. Place of Injury - At II	ome, farm, st	reet, factory, offic	се			r or Rural Route Number,
בַּ	s afta al Dir	Cert	4 Homicide	building, etc. (Special	<i>'y)</i>			City or Towr	i, Sialej	
losoit	within 24 hours after death. To the Funeral Director: After this cartificate has completely filled in by the funeral director, page 2.	edical (rsician: To the best of my knoiner: On the basis of examina						
t ad	the F	Medi	one)	and manner stated.					•	
۵	To cor	-	29b. Signature and title of certifier	Maria		29C. LICE	ense number	2	May	(Month, Dey, Year) 5, 2006
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	Registr		MAY 0 8 2	006	NK A	De School				

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erry Fludiey		I- For State	e of Maryland / L	•	ificate of E		iu ivierii	аі пуді		g. No.	00	C 1/07
Physicia	1/	1. Decedent's Name (First, Middle,La						2.1	Date of Death	E.a.		3. Time of Death
ledical Examin		Jerry L. H	Hudley		14b	City, Town, o	or Location o	of Death	Month April 27, 20	4c. County of		0448 hrs
		Route 210 Charles Count			1	Bryans Ro		Dodai		Charles	Dodin	
Funeral Director			Sex 7. Age (I	•	t birthday) Yrs.	If Under 1 Ye Months Da		Min	. Date of Birth 7-11-1	953	9. Birth Foreign Cou	nplace (State or Washington, ntry)
any		Usual Residence of Decedent 10a. State 10b. County	10	c. City, T	own or Location						\neg	10d. Inside City Limits
<u>*</u> .	٥	MD Prince (George's	Fort	Washir	gton						1 Yes 2 No
th the Maryland 13a or 28a-f sho totified at once.	Director	10e. Street and Number			1	0f. Zip Code 20744				g. Citizen of Wha		•
with the is 23a c		8416 Clay Drive 11. Marital Status	12. Was Decedent Ev	er in U.S	. 13. Was [Decedent of H		in? (Specif		nited St		an Indian, Black,
death	uneral	1 Never Married 2 X Marrie	1 Yes 24	No	If Yes	specify Cuba	an, Mexican,			White,		1-
rs after ural", o	by F	3 Widowed 4 Divorce 15. Decedent's Education (Specify of	or Dates:	eted) I	1 Y	es 2 X N		rind of work	done	Specify: 1		C-2.311
72 houn	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)			of working lif			done	TOD. MING OF BUS	111655/111	laustry
0036 within iene.	Completed		3		Proper	ty Own				Private	<u>, </u>	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Be Be	17. Father's Name (First, Middle, Las Cornelius Hudle	*						rst, Middle, M Black	laiden Surname)		
212 hould b and Men is mar		19a. Informant's Name/Relationship (,				ber, City or Town		
and 2 shou lealth and N teen 27 is n traumatic	-	Carolyn Hudley 20a. Method of Disposition	(wife)	20b. Pl	8416 C				washin ate	gton, MI		
Baltimore, permit. Pages I ar Department of He Important: If ite Imjury or other tr		1 XBurial 2 Cremation 3		cr.	ematory or other Lincol	place)		5/6/		Brentwo		
Baltin permit. P Departme Importan injury or	Ì	4 Donation 5 Other Specification 21. Signature of Funeral Service Lice		<u>i </u>				Fort	inco	In Funer	al	Home
	-	23a. Part I. Enter the dise se, or com		o dooth [ntwood,		20744 Approximate Interval
Physician /Medical		failure. List only one cause on e		e deam. I	DO NOT ENTER THE	mode or dying	y, such as co	ardiac or re	spiratory arre	st, shock, of fleat		Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	uence of):								
	<u>ة</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):	;						\neg	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):							_	7
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760, cate be executed physician and he burial - transit	Medical	UNPENDED	AMENDED									
3876 rtificate ing phy as the	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	of pregna	. —	death 3	Ectopic	pregnancy		23d. Date of o Month	delivery Da	ay Year
Box 687 e death certific the attending p ed for use as th	/sician/l	1 Yes 2 No 9 Unknow	4 Pregnant at tim 9 Unknown	ne of dea	th 5 Othe	(Specify)						
P.O. Box 687 s that the death certification by the attending gedetached for use as it		Part II. Other significant conditions		ut not res	sulting in the und	erlying cause	given in Pa	rt I.	23e. Did tob	acco use contrib	ute to the	he cause of death?
S, P.C uires that n signed b	ed by							- 1		2 V No 3		
cords law requi	Completed	ł 							24a. Was a autops perforr	y pr		opsy findings available ompletion of cause of
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical	<u> </u>			26 Plac	ce of Death (Check only	1 ✓ Yes 2		✓ Yes	s 2 No
Vital sysician shis cen directe	o Be	examiner?	Hospital: 1 Inpatient	2 E	ER/Outpatient		Other ₄	Nursing H		Residence 6	Other:	Scene
Division of Vital Records, and or Attending Physician: The law requires after death at Director: After this certificate has been sited in by the funeral director, page 2 should be	崩	27. Manner of Death	28a. Date of Injury (Month, Day, Year FOUND:)	28b. Time of Inju FOUND:	ry 28c. Inj	jury at Work	lDe		ow injury occurre		road, struck tree
isior Attend or death rector; by the i	icati 	2 Accident Investiga	Apr 27, 2006		0448 hrs	factory, office	Yes 2 ✓		. Location (S	treet and Number	r or Rur	al Route Number, City
Divi	Certification	Suicide 6 Could no determin	of be	•		,	3,		or Town, St	ate)		Bryans Rd., MD
	Medical C	29a. Certifier (Check only one) Certifying Physical Examination	cian: To the best of my k	nowledge ation and	e, death occurred d/or investigation	d at the time, on, in my opinion	date and pla	ce, and due curred at the	e to the cause e time, date a	e(s) and manner a and place, and du	s starte e to the	ed. cause(s)
To vii										29d. Date signe	d (Moni	th, Day, Year)
		AII/W	4/1/			0.0	.M.E.			May 2, 2006	i	
R (5)		 I m and a dress of person who Susan Hogan MD. Ass 	completed cause of dea sistant Medical Exa	•	3a) 111 Penn	Street, Ba	Itimore, N	/ID 2120	1			
Sta		31. Date filed (Month, Day, Year)	32 Registrar's			20						
Registi	ar	MAY 0 9 20	UD Distre	A	No.	-						

	4	For State Registrar	State of	Maryla	nd / Depa <i>Ce</i>	artmen <i>rtificate</i>				tental Hy	/giene Reg. No	2 11 1	6	16273
D1		1. Decedent's Name (First, Middle, Las	st)							2. Date of D	eath			3. Time of Death
Physiciar /Medica		MARIE P. HEARN								Month 5	_ Da	"οη "	06	1415 M
Examine		4a. Facility Name (If not institution, give	e street and num	ber)		4b. City,	Town, or	Location of	of Death		40	. County of	Death	
		Coastal Hospic		he la	Ke	Sal	lisk	VYV				Wic	OM	رزمه
Funeral	1	5. Social Security Number 6. S	ex □ M 2DXF		s. last birthday)	If Under Months	1 Year Days	If Undek Hours	Min.	8. Date of Bi (Month, D	av. Year			ice (State or Foreign
Director	-	219-01-4046 1		82	Yrs.					04-27-	1924	P	ITTS	VILLE, MD
2 3	<u>-</u>	10a. State 10b. County		10c. C	City, Town or Lo	cation							100	d. Inside City Limits
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itural; or items 23a or 28e-f ehow al Exacilitat must be notified at	Director	10e. Street and Number			TITOVI	10f. Zip	Code				10a Ci	tizen of Wha	t Countr	
Sa o	5	7285 TIMMONS STRE	тт			1011 2.5		850			109. 01		it Count	уг
ms 2	Funeral	11. Marital Status	12. Was Deced	dent Ever in	U.S. 13.	Was Deced			ain? (Spe	acify Yes or N	n	USA 14. Race -	America	n Indian
-	ב	1 ☐ Never Married 2 🔀 Married	Armed Ford	Z XNo	1				, Puerto	ecify Yes or No Rican, etc.)			White, et	
all,	ò	3 Widowed 4 Divorced	If Yes, Give Year or Da	tes:		1□Yes 2	2[X] No	Specify:				Specify:	WHI	ΓE
"natural",	Completed	15. Decedent's Ed			16a. Dece	dent's Usua	Occupa	ition			16b. K	ind of Busin	ess/Indu	stry
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Hygien other th	5		4		HO	DMEMAR	KER				OWI	N HOME	[
T 7 5 6	e n	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	, Maiden	Sumame)		
	0	FRANK PARSONS						GRAC	E DA	VIS				
and Men le marke sumatic		19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailir	g Address	(Street a	nd Numbe	r or Rura	l Route Numb	er, City o	or Town, Sta	te, Zip C	ode)
125 E		ROGER D. HEARN -	SON		24 02	FORD	ROAI	O, WE	LLES	LEY HII	LLS.	MA. O	2481	
of Heer filem r othe	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Dames selferer C		Place of Dispo	sition (Nam	ne of			ate		ocation - City		
Department of Important: If Ite eny Injury or of Once.		4 □ Donation 5 □ Other (Specify			TTSVILI	-		· I	5-10-	-2006	РТТТ	CSVII.I.	.F., M	I ARYLAND
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physicien and the burial-transit	EXA	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c .	r as a conse										7. 2
ate has been signed by the attending physicic page 2 should be detached for use as the but completed by Physician/Medical	ysiciallymedic	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 25 No 9 □ Unknown		h 2∐Fet ntattime of	al death 3	Ectopic pre						23d. Date of Month	delivery Da	ay Year
deta b	-	Part II. Other significant conditions co	ontributing to dea	th but not re	sulting in the ur	iderlying ca	use givei	n in Part I.		23e, Did to	obacco u	se contribut	e lo the i	cause of death?
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should should						-			-	-				
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within 24 hours efter death. To the Funsral Director; After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	5	Accident investigation Could not be Homicide determined	28e. Place of	Injury - At h	nome, farm, stre	et, factory,		es 2 N		8f. Location (S City or Tox	Street and m. State)	d Number or	Rural R	oute Number,
within 24 hours efter death. To the Funsral Director; After this certific completely filled in by the funeral director, Medical Certification: To Be C		29a. Certifying Phy (Check only one) Certifying Phy 2 Medical Exam	rsician: To the biner: On the bas and manne	is or examina	owledge, death ation and/or inv	occurred at estigation, i	t the time in my opi	e, date and nion, death	place, a	nd due to the o	ause(s)	and manner place, and o	as state	ed. e cause(s)
To the somp	2	29b. Signature and title of certifier	7 11	h	L Alt	29c.	License	number			29d. Date	signed (Mo	onth, Day	y, Year)
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12 A	2	30. Name and address of nerson who o	ompleted cause	of ath flin	m 23a) /Tuna 5	Print)			-	0		, ,		
Se la la la la la la la la la la la la la	3	30. Name and address of person who c	ompleted cau	of eath (Iter	m 23a) (Type, F	Print)		3	-	lid.	11	N 2	218	6

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State of Maryland / Department of Health and Mental Hygiene

otephen Rober		1- For State Certifi Registrar	cate of Death	Reg. No.	006 1627							
Physic Medical Exam		1. Decedent's Name (First, Middle,Last) Stephen Robert Hill		2. Date of Death Month Day Yea	3 Time of Death 0505 hrs							
A CONTRACTOR OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF TH		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D	May 15, 2006 Death 4c. County c								
	*.	1900 Fletcher Road	Aberdeen	Harford	TRICIOLG							
Funera Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b. 127–38–6492 1x M 2 F 48 Usual Residence of Decedent	irthday) If Under 1 Year If Under 2 Months Days Hours Yrs.	Min. Sept. 10, 1957	9. Birthplace (State or Foreign CountrWirginia							
v any			vn or Location		10d. Inside City Limits							
rland -f show once,	to	MD Harford	Aberdeen		1 Yes 2 X No							
r death with the Maryland or items 23a or 28a-f show any must be notified at once,	I Director	1900 Fletcher Road	10f. Zip Code 21001	10g Citizen of Wh								
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1	13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Pour 1 Yes 2 X No specify:	uerto Rican, etc.) White	- American Indian, Black, , etc. White							
ours afi atural) xamine	d by	or Dates:	a. Decedent's Usual Occupation (Give kinduring most of working life. DO NOT us	d of work done 16b. Kind of Bus								
21215-0036 suld be filed within 72 h Montal Hygiene, marked other than "n te event, the Medical E.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 0	Supervisor	Mail c								
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212 rould by d Ment d Ment is mark	To E		19b. Mailing Address (Street and Number		n, State, Zip Code)							
, MD and 2 st ealth an em 27 i		Karin Klunk (Sister) 20a Method of Disposition 20b. Place		21001 City or Town, State								
Baltimore, MD permit Pages I and 2 sh Department of Health and Important: If item 27 is minyry or other traumat		Burial 2 Cremation 3 Removal from State R. A.	Ferris & Co. 5		ester, PA							
Balt permit Depart Impor		The grant of Funeral Service Licensee	22. Name and Address of Facility Tarring-Cargo Aberdeen, Mar	Funeral Home, P.A yland 21001-3399	A.							
Physiciar /Medica	-	23a. Part I. Enter the disease, or compositations that caused the death. Do failure. List only one cause on each line.	not enter the mode of dying, such as card	ifac or respiratory arrest, shock, or hea	Approximate Interval Between Onset and Death							
Examine		Immediate Cause (Final disease or condition resulting in death) a. Gastrointestinal hemorrhage Due to (or as a consequence of):	je		Deair							
	<u></u>	Sequentially list conditions, if any, leading to immediate b. Rupture of esophageal var Due to (or as a consequence of):	ix									
,	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated)										
cuted and transit	Exa	events resulting in death) Last Due to (or as a consequence of): d. Alcohol abuse										
e exe	Medical	UNPENDED x AMENDED 4c per dy	r g855 5-23-06 v t									
Box 68760, e death certificate be the attending physici ed for use as the buri	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death	2 Fetal death 3 Ectopic pr 5 Other (Specify)	regnancy 23d. Date of o	delivery Day Year							
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ords aw requas beer 2 shoul	Completed			autopsy pi	/ere autopsy findings available ior to completion of cause of							
Rec The l	Col			1 Yes 2 No 1	eath? Yes 2 No							
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n of \ ding Phy After th funeral	i T	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b	o. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurre	-							
		1 Natural 5 Pending Investigation	1 Yes 2 No									
Divisual or /	Certification:	3 Suicide 6 Could not be determined (Specify)	, farm, street, factory, office building, etc.	28f. Location (Street and Numbe or Town, State)	r or Rural Route Number, City							
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	edical C	23a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated										
F × F S	ğ											
5		30. Name and address of person who completed cause of death (Item 23a										
5			111 Penn Street, Baltimore, MD	21201								
Regi	State strar	31. Date filed (Martin Asy, 2ear 2006 32 Registrar's Signature	Apolle									

			1 - For State Registrar	State of Ma		epartme Certific			d Me	_	giene)	162	75
	Physici	an	Decedent's Name (First, Middle, La	st)					2.	Date of De Month	Day	y Yea	ar	3. Time of	
	/Medi	cal	David Jaeger				-			May	9	20		1:00	A M
	Examir	ier	4a. Facility Name (If not institution, giv					r Location of De			4C.	County of D	eath		
	Funeral		26 Wallamsey Land 5. Social Security Number 6. S		e (In yrs. last birt	hday) If Un	der 1 Year	eake Ci		Date of Bir (Month, Da	th	Cecil 9.1	Birthplace	e (State or	r Foreign
	Director		078-38-9783	XM 2□F	46	Yrs. Monti	ns Days	Hours M	lin. Ma	(Month, Da Urch 2	iy, Yθar) 4	1960	Country)	NY	
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							104	Incide Cit	. I imit
	shov	5					0.4							Inside Cit	
	28e-f	ect	MD Cecil 10e. Street and Number		Chesa	peake	CLTY Zip Code				10a Citi	izen of What			
	3e or	Funeral Director	26 Wallamsey Lav	10			2191	5			, - g,	USA	oouy		
	death ms 2 rmm	nera	11. Marital Status	12. Was Decedent 8	Ever in U.S.	13. Was De		lispanic Origin? an, Mexican, Pu	(Specif	y Yes or No	-	14. Race - A			
9	after or fle	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕱 N If Yes, Give	lo		pecify Cuba 2 1 X No	Specify:	erto Hid	an, etc.)		Black, W Specify:	mite, etc. Whi		
003	ural',	d by	3 Widowed 4 Divorced	Year or Dates:	223		. ,								
15-	within 72 hours after death with the Maryland ane than "netural", or Items 23e or 28e-f show the Madigal Exhibited of the Madigal Exhibited at	lete	15. Decedent's El (Specify only highest gra	ide completed)		Decedent's U (Give kind of life. DO NO	sual Occup work done Luse retired	ation during most of v d)	working		16b. Ki	ind of Busine	ss/Indust	try	
21215-0036	with iene. Than	Completed	Elementary/Secondary (0-12)	College (1-4or 5 5 +	+)	Physia		-,			Ph	usiat	711		
	e filed al Hygie other vent.	Bec	17. Father's Name (First, Middle, Last,					18. Mother's N	Name (F	irst, Middle,			<u> </u>		
/lar	2 should be f and Mental F is marked of raumatic aver	10 E	Stanley Jaeger					Harri	et 1	evins.	on				
Maryland	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Health and Mental Hygiene. ortent: If item 27 is marked other than "netural", or Items 23e or 28e-f show injury or other traumatic avent. The Maddial Extentine frout be notified at 9.		19a. Informant's Name/Relationship (and Number or				r Town, State	e, Zip Co	de)	
	1 and Health em 27 Ither tr		Steven M. Jaeger/ 20a. Method of Disposition	brother				Roslyn	Hei	hts,	NY	11577 ecation - City	Taum	Chata	
Baltimore,	ages or of h		1 X Burial 2 ☐ Cremation 3 X		20b. Place of cemetery			, 00	-11-	2006				State	
Iţin	permit. Pages Department of Importent: If it any injury or o		 4 □ Donation 5 □ Other (Specif 21. Signature of Funeral Service Lice 		New Mo				_	- ,	Pin	ielawn,	NY .		
Ba	Depa Impo any ir		Land L	and	2	318 G	י מונה לה	ss of Facility R Street	CI	toard	tun	ieral f	iome,	7131	5
	TES NO		23a. P. 11. Enter the disease, or com	plications that caused	the death. Do n		-					creage,	Ap	proximate erval Betw	1
	Physician		Immediate Cause (Final disease or condition		ge Hunt	innton	Dixo	a k o					On	iset and D	eath
	/Medical		resulting in death)		a consequence of		vise	use					1		-
	Examiner		Sequentially list conditions.		tion Pne										
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a Consequence o	t _j .									
	and and al-tran	хап	that initiated events resulting in death) Last	cDue to (or as :	a consequence o	f):							-		
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	icai E	l l	d											
89	g phy as the	edic		- U											
ŏ	death certifica attending ph d for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		3 ☐Ectopic	Dreamanou	,			1.2	23d. Date of			
). B	e deat	sicis	in the past 12 months?	4☐Pregnant at 9☐Unknown		5 Other				**		Month	Day	y Ye	ear
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S,	ires tha signed the det	by	Part II. Other significant conditions of	onthouting to death bi	it not resulting in	tne ungeriyin	g cause giv	en in Paπ i.				ise contribute ∃No 3⊟			
Ö	w require been si should I	etec							-	-		1			
Records,	he law has ge 2 :	Completed							-	24a. Was autop perfo		24b. Were prior to death	o comple?	etion of car	
Vital	sician: The law certificate has t irector, page 2 s	ပိ	25. Was case referred to medical					26. Place of D	loath (C	1 🗌 Yes	2A No	1 DY	es 2	No No	
>	Physician: r this certifica ral director, i	0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2 ER/Out	patient 3	DOA Oth	er: 4 \(\text{Nursing}				3 ∏Other (S	pecify)		
	iding Physician: th. : After this certifica funeral director, p	T:U	27. Manyer of Death 1 ■ Natural 5 □ Pending	28a. Date of Injur (Month, Day	y 28b. T		28c. Injun Wor	y at		. Describe I					
ioi	Attending r death. ector: After by the fune	atic	2 Accident investigation	1		М		Yes 2 □ No							
Division	or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	Iry - At home, far c. (Specify)	m, street, fac	ory, office		28f.	Location (S City or Tox	Street and vn, State,	d Number or)	Rural Ro	ute Numb	er,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		200 Codifier 1 VCodificing Bh	uniniam. To the best of	d and beautiful	d = 40				-d 4 4b					
	Hos 24 ho Fune stety f	Medicai	29a. Certifier 1 XCertifying Ph (Check only 2 Medicel Exar	ysician: To the best on niner: On the basis of and manner sta	examination and	death occurr Vor investigat	on, in my o	ne, date and pla pinion, death oc	curred	at the time,	cause(s) date and	and manner place, and d	as stated ue to the	d. cause(s)	
	o the	Me	29b. Signature and title of certifier	1			29c. Licens	e number			29d. Dat	e signed (Mo	nth, Day,	, Year)	
	-> P 0) Albe	W			010	00552	9		5/	9/06			
			30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, Print)	Vino	00552 d Kripal	lu.	M.D.	-	-			
	5		314 Kelway Plaza	, ST# 103,	Newark	, DE	19711								
	Sta		31. Date filed (Month, Day, Year) MAY 1 0	2005 32. Redistra	r's Signature	Sec	le								
	Regist	ali	111/11 = 0	- TO THE REAL PROPERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE PERTY OF THE P	4	-	The same								

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			1 - For State Registrar	State of Maryland		irtment of H tificate of I		nd Mental Hy	/giene / Reg. No.	2006	16270
	Dhusisi		1. Decedent's Name (First, Middle, La					2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medio		Louis Plowe	den Jenkins				May	6	2006	3:08A M
	Examin	er	4a. Facility Name (If not institution, given 309 Spruce St			4b. City, Town, or		Death	4c. C	ounty of Deat	
			5. Social Security Number 6. S		highday	La P	lata If Under 2	4 Hrs 0 Data of 0		Char	
	Funeral Director			2 F 80	Yrs.	Months Days	Hours	Min. (Month, D.	$\overset{\text{nn}}{29}, \overset{\text{Year}}{19}$	9. BIR	hplace (State or Foreign untry) Maryland
	ס		Usual Residence of Decedent				l	March	Z9,1:	720 1	Mai y Lanu
	arylan show	_	10a. State 10b. County Char	les 10c. City, T							10d. Inside City Limits
	8a-f	octo		Li	a Pla						1X Yes 2 No
	with t	ă	10e. Street and Number 309 Spruce St	treet		10f. Zip Code	206	46	10g. Citize	n of What Co USA	untry?
	death ma 23	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. V	Vas Decedent of H	spanic Origi	in? (Specify Yes or No	0- 14	. Race - Ame	ncan Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 ie marked other than "natural; or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at once.	Completed by Funeral Director	1 ☐ Never Married X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	lf If	Yes, specify Cuba ☐ Yes 2 No	n, Mexican, Specify:	Puerto Rican, etc.)		8lack, White	
21215-0036	72 hou	ted	15. Decedent's E		6a. Deced	ent's Usual Dccup	ation	-1	16b. Kind	of 8usiness/	Industry
21	thin 7	nple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life. [kind of work done o O NOT use retired	<i>furing</i> most of	of working			
2	ygien ygien her th	Co		5+	At	torney				aw	
Maryland	d be findal H) Be	17. Father's Name (First, Middle, Last, Francis Plowde:					s Name <i>(First, Middle</i> .se Steve		ımame)	
2	should nd Me mark matk	은	19a. Informant's Name/Relationship (19b. Mailin	Address (Street a		or Rural Route Numb		own State Z	in Code)
ž	alth a alth a 27 is		Gladys Jenkins					Plata,MD		646	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ore	of He of He fitem r oth		20a. Method of Disposition 1 ➡ Burial 2 ☐ Cremation 3 ☐		e of Dispos	sition (Name of atory or other place	a)	Date	20c. Loca	tion - City or 1	Town, State
Ě	Pag ment lant: I		4 Donation 5 Other (Specif			atius C	em. 5	5/11/06	Port	Toba	cco,MD
Baltimore,	Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Departiment Depart		21. Signature of Funeral Service Licer	S FUNERA	L HO	ME,P.	A. D. 20646				
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. I						ain, cu	Approximate Interval 8etween
1	Physician		Immediate Cause (Final disease or condition	a Prostate	_ 4	ancer					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequen	ce of):						
		-	Sequentially list conditions,	b. Due to (or as a consequen-	ed off):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		,						
o	en an rial-tr	Exa	resulting in death) Last	Due to (or as a consequen-	ce of):						
58760,	es thet the death certificate be executed gned by the ettending physicien and be detached for use as the burial-transit	dlcal		d							
_	ertific ding p	a	IF FEMALE:	00- 1							
Bo	ettend for us	clan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death	ath 3 🔲	Ectopic pregnancy			230	d. Date of deliver Month	very Day Year
P.O. Box	the d	Physician/M	1 ☐ Yes 2 🗖 No 9 ☐ Unknown	9□ Unknown	. 30	Other (specify)					,
	s thet ned b e deta	by PI	Part II. Other significant conditions of				n in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
ğ	w require been sig should b	edt	Chronic lyn	y hocy til	Ca K	ing		1	Yes 2□N	No 3∏Pro	bably 4 Unknown
ecc	law ri as be 2 shi	Completed						24a. Was	an 2	24b. Were aut	opsy findings available ompletion of cause of
<u> </u>	Physicien: The lav this certificate has al director, page 2 a	Con						perfo	rmed?	death?	
/ita	cien: ertific ector.	Be	25. Was case referred to medical examiner?					f Death (Check only o			
<u></u>	Physic this c	2	1 ☐ Yes 2 X No 27. Manner of Death		Outpatient		4 Nuis	ing Home 5 AResid			r(y)
L _O	ding h. After funer	tlon	1 Natural 5 ☐ Pending	(Month, Day Year)	b. Time of Injury	28c. Injury Work	at ? ′es 2∐No	28d. Describe I	now injury o	ccurred	
Division of Vital Records,	Attending Physicien: The law requires thet the death certif r death. ector: After this certificate has been signed by the ettending by the funeral director, page 2 should be detached for use a:	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At home	, farm, stre		00 2 110	28f. Location (S	Street and N	lumber or Rur	al Route Number.
	s afte	Certification;	4 Homicide determined	building, etc. (Specify)				City or Tov	vn, State)		
	To the Hospitel or Attending Ph Within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier 12 Certifying Ph (Check only one) 2 Medical Exen	ysician: To the best of my knowled niner: On the basis of examination and manner stated.	dge, death and/or inve	occurred at the timestigation, in my op	e, date and i inion, death	place, and due to the occurred at the time,	cause(s) and date and pla	d manner as s ace, and due t	stated. to the cause(s)
	vithin o the	Mec	29b. Signature and title of certifier	THE HIGH STATES.		29c. License	number		29d. Date si	igned (Month,	Day, Year)
	->-0		15 %	1 ms		D 33	426				3, 2006
0		Ī	30. Name and address of person who	corpoleted cause of death (Item 23.	a) (Type, P	rint)				,	
	320		Larry Jenkins,	M.D. 111 La G	rang	e Ave.	La P1	Lata,MD 2	0646		
4	Sta Registr:		31. Date filed (Month, Day, Year) MAY 0 9	32. Redistrar's Signature	4. 6	Goods					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HELEN MAY JONES MAY 16 2006 10:18a M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Center Chestertown Kent If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. NOV 1 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛣 F Maryland 81 Director 215-44-6927 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fehow other treumatic event, the Modical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No MD Kent Chestertown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 or Items 23e 5886 Honest Point Lane 21620 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify White 3 ₩ Widowed 4 Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mental : Department of Health and Mental : Important: If item 27 is marked of any injury or other treumatic even QDGE. 2 should be fi and Mental H Willie Michael Pardee Lydia Madora Foreman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughter) 23456 Lovely Lane Chestertown, MD. 21620 Mable J. Myers 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

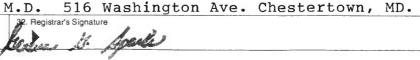
Burial 2 □ Cremation 3 □ Removal from State 5/21/06 * 4 ☐ Donation 5 ☐ Other (Specify) Chester Cemetery Chestertown, MD. Funeral Service Lansee 2. Name and Address of Facility alena Funeral Home of Stephen L. Schaec 118 West Cross St. Galena, MD. M00510 21635 23a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** dan disease or condition resulting in death) /Medical Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed as the burial-transit newosch that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. I the a 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 9 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy perform 2 No 2 No 1 Tes To the Hospital or Attending Physician: 25. Was case referred to medical funeral director 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification; 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 Tes 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 | Homicide 24 hours a 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year)

State Registrar

MAY 2 3 2006

Susan K. Ross,

31. Date filed (Month, Day, Year)



500 M.D)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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D1703C

7/06

			1 - For State Registrar	State o	f Maryla	nd / Depa <i>Cei</i>		nt of H <i>te of L</i>		and Mo		giene No. No.	006	16278
	Physici /Medio		Decedent's Name (First, Middle, L MARY LEE KEY	ast)							2. Date of Dea MAY 6,		Year	3. Time of Death 3:00P M
	Examir		4a. Facility Name (If not institution, go CASEY HOUSE	ve street and nur	nber)			, Town, or	Location o	of Death			nty of Death	RY
	Funeral Director			Sex 1 M 2 F	7. Age (In yrs 45	. last birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	8. Date of Birtl (Month, Day UGUST 30	Year) , 1960	Cou	place (State or Foreign ntry) INGTON, DC
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene Health and Mental Hygiene Health and Mental Hygiene "natural", or items 23a or 28e-f show titem 27 is marked other, the Madical Examinar must be roofflied at	by Funeral Director	10a. State 10b. County MD MONTGOM 10e. Street and Number 10801 AMHURST AVE 11. Marital Status X Never Married 2 Married 3 Widowed 4 Divorced		SIL	l	1 NG	ecify Cubai		gin? (Spec i, Puerto R	cify Yes or No-		of What Cou D STAT ace - Amen lack, White,	can Indian, etc.
Maryland 21215-0036	e filed within 72 hou il Hygiene. other than "natura vent, the Medical E	Be Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1		16a. Deced (Give life. L	kind of w	ork done d use retired)	u <i>ring</i> most	TOR	g (First, Middle,	16b. Kind of MANAG Maiden Sum	EMENT	
arylar	should be and Mental s marked o umatic eve	To B	JAMES P. KEY 19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Addres	s (Street a			Route Number		n, State, Zip	Code)
	s 1 and 2 if Health a item 27 is other trav	0.000	LULA KEY/MOTHER 20a. Method of Disposition			1720 Place of Disponentery, crem	sition (Na	me of	T		E, LAN	DOVER,		
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		1 🖾 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Surface of Funer in Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Server 1 & Communication of Serve	i(y)		RT LINC	OLN		M		, 2006 I			
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8760,	/Medical Examiner buysicien and burial-Itansit sthe purial-Itansit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	STATIC or as a conse	quenca of):	ANCE	IR						Onset and Death
O. Box 6	The law requires that the death certificate be executed te hes been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ANO 9 □ Unknown		irth 2 ☐ Fet ant at time of	al death 3 [Ectopic p Other (s	oregnancy pecify)					ate of delive	ery Day Year
rds, P	w requires that been signed b should be deta	Ď	Part II. Other significant conditions	contributing to de	ath but not re	sulting in the un	derlying	cause give	n in Part I.		23e. Did to			ne cause of death?
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DIVIS	E Diffe	Certification:	3 Suicide 6 Could not 4 Homicide determined	286. Place	of Injury - At h	nome, farm, stre ify)	et, factor	y, office		28	If. Location (Si City or Town		nber or Rura	l Route Number,
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}	To the within 2 To the complet	Σ	29b. Signature and title of certifier		~	"		c. License			2	9d. Date sign		
1	B 22		30. Name and address of person who JOSEPH KAPLAN			m 23a) (Type, F STER MI	Print)			VILLE	, MD 20		_ 2000	
	Sta Registr		31. Date filed (Month, Day, Year) AY 1 0	32. 🖼	gistrar's Sign	ature								

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		1 - State Registrar				Cei	tificate of	Death			Reg. No.	4 0 0 0	10273	7
Physi	ician		me (First, Middle,						1	Date of Dea Month	ath Day	Year	3. Time of Death	
/Med	dical		Rita Ko	lb give street and num.	harl	OI	4b. City, Town, o	or Location	of Death	May	08	2006 County of Dea		_
Exam	niner			an Villag		Ctr th Car	•				40.	Carro		
Funera	al	5. Social Security		. Sex 7		last birthday)	If Under 1 Year		er 24 Hrs.	8. Date of Birt (Month, Da	h V Voar)		thplace (State or Foreign ountry)	7
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and w		Usual Residence	of Decedent 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits	-
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death with the Maryland ms 23a or 28e-f show	Funeral Director	10e. Street and N	lumber				10f. Zip Code				10g. Citiz	en of What Co	ountry?	_
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er dea	nner	11. Marital Status		12. Was Deced	es?	.S. 13. \	Vas Decedent of H Yes, specify Cub	lispanic C an, Mexica	rigin? (Spec an, Puerto Ri	ify Yes or No- ican, etc.)	- 1	 Race - Ame Black, Whit 		
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arylar should be and Menta is marked eumatic ev	P		Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street					Town, State,	Zip Code)	
Md 2 allth a 27 is ritre		Edward	J. Kolb/	husband			8 Weller		Westn	ninster	, M	2115	8	
Baltimore, IN Department of Health Mportent: If item 27 any injury or other tr	1	20a. Method of D		☐Removal from S	20b. F	Place of Dispo semetery, cren	sition (Name of natory or other plac	сө)	5/123	2006		ation - City or		
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Baltimo permit. Pages Department of Importent: If i	once.		Funeral Service Lie	1		P1	Name and Addre	eral	Home	and Ch	apel	, P.A. er, MD	21157	
1	7	23a. Part1. Enter shock, or he	r the disease, or co eart failure. List or	omplications that cally one cause on ea	used the deat ch line.	h. Do not ent	er the mode of dyir	no, such a	s cardiac or	respiratory ar	rest,	er, m	Approximate Interval Between	
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ysicien: The is certificate director, pag	Be	25. Was case ref	erred to medical							(Check only o				_
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ding Ph ding Ph h. After th funeral	tion	1 DMatural 2 Accident	5 Pending	28a. Date of (Month	, Day Year)	Injury	28c. Injur Wor M 1 🗀	rk? Yes 2[od. Describe r	iow injury	OCCUITED		
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root	Annual Section (Section Section •	beck				D	52	072		100	9 9	2006		
6		30. Name and ad	dress of person wi	no completed cause	of death (Item	n 23a) (Type,	Avenue		Westn	niniste	1	MD 21	1157	
Regi:	State strar	31. Date filed (Mo	MAY 0 9	2006 32. Be	gistrar's Signa	iture	29c. Licens D Print) Avenue							
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DHMH 17 Rev 1/2001

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	* %	W.	Ragistrar Decedent's Name (First, Middle, Last)	t)		Crimean	0 01 2	Joann	2	2. Date of Dea		00	3. Time of Death
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	Funeral Director			² № 2√ F 88		Months	Days		Min.	B. Date of Birth (Month, Day Jun 16,	1917	9. BIRTH	place (State or Foreign Intry)
-	70		Usual Residence of Decedent							dir 10,	1017	•	
	show	2	10a. State 10b. County MD Allegan	v	10c. City, Town or	Location aptowr	3						10d. Inside City Limits Y☐ Yes 2☐ No
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36	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or iteme 23s or 28s-f show avent, I're Medicel Exeminer must be multified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 N	0	1 🗆 Yes		Specify:]	white	
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Maryland 21215-0036	I be fill hall H ed oth	Be	17. Father's Name (First, Middle, Last) Elmer Roy Mello	•						First, Middle, I Barne)		,	
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 le marked other than "natural", or iteme 23a or 28a-1 show other traumatic avent, it is Medical Exempler must be notified at	은	19a. Informant's Name/Relationship (7		19b. Ma	ailing Address	(Street a			Route Number			p Code)
	and 2 salth ar n 27 le		Donna Knick	daugh		'19 Mai				Cresap			21502
Baltimore,	of He of He filter		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Domoval from State	20b. Place of Dis	sposition (Nan rematory or o	ne of ther place	a)	Dat	9	20c. Location	- City or T	own, State
Ĕ	Pages tment of I tant: If It		4 □ Donation 5 □ Other (Specify)	Sunset Me						Cumbe	erland	MD
Ba	permit. Pages Department of I Important: If Its any Injury or o		21. Signature I Funeral Service Licen	9/1	1/11	22. Name an Sca							
			23a Part1. Enter the disease, or comp	lications that caused	the death. Do not	108 enter the mod	Virgin	nia Aver	nue: C	Cumberla	and, MD	21502	Approximate
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9	rtificat ng phy as th	Medi	(5.55), (1.5)	u									
Box	ath cei tendir	an/h	fF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of		3 ⊟Ectopic pr	egnancy				1	ate of delive	
o.	the all	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime of death	5 ☐ Other (sp	ecify)				M	Onth	Day Year
J.	w requires that the de been signed by the should be detached		Part fl. Other significant conditions co	ntributing to death bu	t not resulting in the	underlying ca	ause give	n in Part I.		23e. Did tot	pacco use cor	ntribute to t	he cause of death?
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000	aw rec	piete								24a. Wasa		Were auto	ppsy findings available
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6	0 - 40	7	1 ☐ Yes 2 No 27. Manner of Death	Hospitaf: 1 ☐ Inpatier 28a. Date of Injury				4 Nursi		5 Reside			ý)
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DIVISION OF	Attar er dea ector by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm,	street, factory	, office		28f			ber or Rura	al Route Number,
5	ital or rs afte al Dir led in	Cert	- I Tormoldo	Duliding, etc.	(Specify)					City or Towr	i, Siale)		
	To the Hospital or Attanding Physician: within 24 hours after death of the Funeral Director. After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Exam	sician: To the best of inar: On the basis of	examination and/or	ath occurred a investigation,	at the time in my op	e, date and p inion, death	place, and occurred	d due to the ca	use(s) and mate and place,	anner as s	tated. the cause(s)
	o the ithin 2 o the	Med	one) 29b. Signature and title of certifier										
	アリドル		> workerfly	lini	MD	Y	000	5532	15		Mari	12	2006
	1.		30. Name and address of person who o	ompleted cause of de	ath (Item 23a) (Typ	e, Print)			()		5		
	U			VMD 4	r larn 7	ewac	re	Frost	thive	& MO	2153	2	
	Sta Registr		31. Date filed (Month Pay 2° 3° 20	16 Registra	MD ath (Item 23a) (Typ	party.							

			1 - For State Registrer	State of Marylar		rtment of H			giene Rag. No.	5 16281
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last) 3 0 b 7 4a. Facility Name (If not institution, give stre	Land	0	4b. City, Town, or	Location of Death	2. Date of De Month	Day Ye	of 8 30 AM
	Funeral Director		5. Social Security Number 6. Sex 152 N	rewist Ho 7. Age (In yrs. 53	SPIPOL last birthday) Yrs.	Il Under 1 Year Months Days	II Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sep.,	Mon 12, 1952 1	Birthplace (State or Foreign Country) North Carolina
	e Maryland Sa-f e how	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Geo		y, Town or Loc					10d. Inside City Limits 1 Yes 2 □ No
	23a or 21	Funeral Director	10e. Street and Number 5423 16th Avenue #1	04		10f. Zip Code 20782			10g. Citizen of What	Country?
920	within 72 hours after death with the Maryland one. then "natural", or Itema 23a or 28a-1 ehow the Medical Evantirar roual be notified at	by	11. Marital Status 12. 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates:	If	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 ☑ No	spanic Origin? (Si n, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		merican Indian, /hite, etc. Black
Maryland 21215-0036	be filed within 72 hours after death with the Maryla lal Hygiene. Id other then "natural", or Itema 23a or 28a-f ehov event, Tra Medical Examinar must be notified at	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	ion ompleted) College (1-4or 5+)	(Give k	ent's Usual Occupa and of work done d O NOT use retired)	urina most of wor	king	16b. Kind of Busine	Government
land		To Be C	17. Father's Name (First, Middle, Last) Un known					ne (First, Middle, Mae Dan	Maiden Surname)	
	nd 2 : lith ar 27 le r trau		19a. Informant's Name/Relationship (Type, Eula Lane/Wife	Print)		Address (Street a			ar, City or Town, State	e, <i>Zip C</i> ode) 20782
Baltimore,	Se to L		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State		ition (Name of atory or other place n Cemete)	Date 3/2006	20c. Location - City Brentwood	or Town, State , Maryland
Balt	permit. Page Department Important: If eny injury o		21. Signature of Funeral Service Licensee	ille	Ft	Name and Address Lincol 01 Blade	n Funera	1 Home d., Bren	ntwood, MD	20722
8760,	death certificate be executed Wedical by Sicien and entending physicien and for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one disease or condition resulting in death) 5 Squantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence to (or as a consequence)	uence of):	erotic	Hea	1 -	isease	Approximate Interval Between Onset and Death
.O. Box 6	che the	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	II yes, outcome of pregnant 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	Ideath 3⊟8	Ectopic pregnancy Other (specify)			23d. Date of o Month	delivery Day Year
Δ.	sign d be	by	Part II. Dther significant conditions contnt	outing to death but not resu	ulting in the und	derlying cause giver	n in Part I.			to the cause of death? Probably 4 Inknown
al Records,	The ate h page	Completed						24a. Was a autop perfor	sy prior t	
ion of Vital	Jing Phys The This funeral dir	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hose 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Dital: 1	ER/Outpatient 28b. Time of Injury	3200A Other 28c. Injury Work?	4 Nursing no	ome 5 Resid	ne) lence 6 □Other (S _i ow injury occurred	pecify)
Division	al or Attences after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place ol Injury - At ho building, etc. (Specify	ome, farm, stree	et, lactory, office		28l. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying Physici 2 Medical Examiner	an: To the best of my know On the basis of examinat and manner stated.	wledge, death of the tion and/or inve	occurred at the time estigation, in my opi	a, date and place, nion, death occur	and due to the c red at the time, c	ause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the H within 24 To the Fl complete	M	29b. Signature and title of certifier	Sino		29c. License	557/8	2	29d. Date signed (Mo	nth, Day, Year)
R	(5)		30. Name and address of person who comp	leted cause of death (Item CVENT:ST	23a) (Type, P	rint) tal, T	takon	na Par	-K, MI)
	Sta Registr	7.00	31. Date filed (Month, Day, Year) MAY 0 9 2006	32. Registrar's Signat	ture					

			, FOI	artment of Health and M rtificate of Death		ene 9. Noc o o c	10000
1	Physici	an	1. Decedent's Name <i>(First, Middle, Last)</i> Peggy Jean Morgan		2. Date of Death Month	Day Year	3 Time of Death
	/Media	cal	<u> </u>		May 8,	2006	09:30 A M
1	Examir	ner	4a. Facility Name (If not institution, give street and number) 144 Rolling Avenue	4b. City, Town, or Location of Death North East		4c. County of Dear	th
3	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign
	Director		478-64-9124 1□ M 2XF 53 Yrs.	Months Days Hours Min.	(Month, Day, 1 une 4,	1952 Iow	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mary	tor	Maryland Cecil North Eas	t			1 ☐ Yes 2 💆 No
	or 28s	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	ountry?
	s 23e		144 Rolling Avenue	21901		nited Stat	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If Item 27 is marked other than "naturel", or Itams 23a or 28s-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral	1 ☐ Never Married 2X Married 1 ☐ Yes 2X No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 X No <i>Specify:</i>	offy Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
21215-0036	2 hour	ted t	15. Decedent's Education 16a. Dece	dent's Usual Occupation	10	6b. Kind of Business/	Industry
215	e. an "n	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)	g		·
	filed wi Hygien other th			memaker	(Fire Middle 44	Own Hom	e
Maryland	d be find H ed off	Be	17. Father's Name (First, Middle, Last) John R. Morgan	18. Mother's Name Betty M.			
aryl	should be find Mental had Mental had marked of	To		ng Address (Street and Number or Rural			Zip Code)
	and 2 Balth a n 27 ls		William A. Bear/spouse 144 F	tolling Avenue, Nor		, Maryland	21901
Baltimore,	Pa Int		i bunar 2 Cremation 3 Demovar from State	matery or other piece)		oc. Location - City or Newark, De	
Balt	permit. Departr Importe eny inje			2. Name and Address of Facility Cro			land 21901
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not eni shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	er the mode of dying, such as cardiac or	respiratory arres	it,	Approximate Interval Batween Onset and Death 2 - years
68760,	ficate be executed physicien and s the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
	w requires that been signed I should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I,		cco use contribule lo	•
of Vital Records,	The law requir ate has been si page 2 should	Completed			24a. Was an autopsy performs	prior to d	lopsy findings available completion of cause of
Vita	ding Physician: The h. After this certificate h: funeral director, page	Be	25. Was case referred to medical examiner?	26. Place of Death			
o	Phys r this ral dir	. To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier 27. Manner of Death 28a. Date of Injury 28b. Time o		e 5 KResiden 8d. Describe how	ce 6 Other (Spec	cify)
ion	nding tth. :: Afte	ation	1 Matural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	28c. Injury at 26 Work? M 1 Yes 2 No	od. Describe now	injury occurred	
Division	al or Attend after death Director: d in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	Bf. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatly one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	estigation, in my opinion, death occurre	d at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the To the Comp	Ň	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month	n. Day, Year)
			H Herkes, My	015714	N	lay 10, 20	806
	10		30. Name and address of person who completed cause of death (Item 23a) (Type,	print) Nice Elkton	40	,	
	Sta Registr		29b. Signature and title of certifier ### Howker, *** 30. Name and address of person who completed cause of death (Item 23a) (Type, ** ### Howker, *** #### Howker, *** #### States of the cause of death (Item 23a) (Type, ** ##################################	Sparte			

DHMH 17 Rev 1/2001

Certificate of Death Consciours Name (First Medical Last) Share and State (See See See See See See See See See S				1 For State	State of Marylan	d / Depa	artmer	nt of He	ealth and	_	/giene	_	15283
Mary Elizabeth McLean Mary Flizabeth McLean Mary 7, 2006 for Mary 10:48pt Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Date Leading Town of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of Landand of L				Registrar		Cei	lilica	le UI D	Calli	2 Date of D	Reg. No.		3 Time of Death
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 10:00 Am MAY 05 Mary Lucy Mason 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Anne Arundel Arnold FutureCare Chesapeake If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1 ☐ M 2 🗙 F Yrs. 89 May 17, 1916 Director 441-70-0822 Usual Residence of Decedent Jemit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene.
mportant: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2√2 No Severna Park Anne Arundel MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21146 43 West McKinsey Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yas 2 ☑ No Specify: Baltimore, Maryland 21215-0020 Š 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Verna Agnes Baker Joel Benjamin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 480 Lymington Road, Severna Park, MD 21146 Verna Galloway/Daughter injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition May 12, 2006 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oklahoma City, OK Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Ho 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee P.A. Severna Park Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical PNEUMONIA Examiner Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yas 2 💢 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed ANEMIA SIP LUMBAR FUSION AND LAMINECTOMY is certificate hes t director, page 2 s TUYES 2000 1 □ Yes 2 □ No To the Hospital or Attending Physician: Within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | O Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stare) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D57531 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 VETERANS HWY, MILLERSVILLE MD 21108 Mohit Neg 32. Pagistrar's Signature 31. Date filed (Month, Day, year)

State Registrar

		_	For State Registrar		Marylan	d / Depa	artment of H	lealth a	nd Me	ental Hyg	eg. No.	06	1628	35
	Physicia	an	Decedent's Name (First, Middle Decedent's Name (First, Middle						1	Date of Deat Month	th Day	Year	3. Time of De	
	/Medic	al	Dorothy	Lillia			Murchie		15 "	May	1	2006	1620	М
	Examin	er	4a. Fecility Name (If not institution Anne Arunde1 M	•			4b. City, Town, or		Death			ty of Death		
7	Funeral		5. Social Security Number			last birthday)	Annapo If Under 1 Year	If Under 2		B. Date of Birth		nne Ar	unde1 lece (State or F try)	oreign
	Director		104-18-6715 Usual Residence of Decedent	1□M 2\\ F	80	Yrs.	Months Days	Hours	Min.	(Month, Day, Oct. 5,	1925	New		
	yfand how		10a. State 10b. County		10c. Cit	y, Town or Lo	ecation					1	0d. Inside City	Limits
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9	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. Add other than "natural", or items 23a or 28a-f show event, it a Madical Examinar must be redified at	by Funeral Director	11. Marital Status 1 □ Never Married	Armed Force	es? ☑ No	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2	Specify:	Puerto R	ican, etc.)		lack, White,		
212-0030	2 hou	ted	15. Deceden	's Education		16a. Dece	dent's Usual Occup	ation			16b. Kind of	Business/Inc	dustry	
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7	ad wit /giene er tha	Completed	12			Home	maker				Own I	lome		
yland	d oth	Be	17. Father's Name (First, Middle,	Last)				18. Mother	r's Name ((First, Middle, I	Maiden Suma	ame)		
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Mar	d 2 st th and 7 ls n treun		19a. Informant's Name/Relations Edward T. Murc		.4)		ng Address (Street							
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ᅙ	ages ant of nt: If if		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ile		natory or other place les Cem.		-5-20	206	Farmin	odele	NTV	
baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any injury or other treumatic evonce.		21. Signature of Funeral Service				2. Name and Addres	ss of Facility	/			iguare	, NI	
ñ	E E E E		17/ 12.	Jan-			Hardesty 12 Ridge	Tune	ral i	Home, P . Annap	.A. olis.	MD 21	401	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau only one cause on eac	sed the deat	h. Do not en							Approximate Interval Betwe	en
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П	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):)							
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	ned Insit	min	Cause (Disease or injury	\$ 550.00	40 4 00//304	40 1100 01).								
<u>,</u>	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or	as a conseq	uence of):								
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9	death certificate e attending phys od for use as the	Med	IF FEMALE:											
X P P	death certific attending pl	Physician/Med	23b. Was decedent pregnant in the past 12 months?		2 ☐ Feta	I death 3	Ectopic pregnancy	,				ate of delive	ry Day Yea	ar
		ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregnan 9□Unknow	t at time of d	eath 5	Other (specify)						,	
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	ftel ftel	ion:	27. Manner of Death 1 ■Natural 5 □ Pendir		njury <i>Day Year)</i>	28b. Time o Injury	Worl			3d. Describe ho	w injury occi	urred		
DIVISION	or Attending after death. Director: Afte in by the fune	icat	2 Accident investi 3 Suicide 6 Could	-	Injury - At he	ome farm et		Yes 2□N		Rf Location /St	reet and Nun	nher or Rura	l Route Numbe	
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	Fo the within Fo the comple	Me	29b. Signature and title of pertile				29c. License	e number		2	9d. Date sign	ed (Month,	Day, Year)	
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			30. Name and address of person How France		of death (Item	1			l ce	nh.	Duna	pilis	MDZ	i 40
	Sta		31. Date filed (Month, Day, Yeer)	32 Aeg	istrar's Signa							4		
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/Medi		Martha V. M			- CI					May		300	6:45 рм
Examir	ner	4a. Facility Name (If not instituti			Ctr.			Location o			4c. County	of Death	
Euporal		Carroll Luther 5. Social Security Number		. Age (In yrs.		If Under	1 Year	If Under		8. Date of Bird			place (State or Foreign ntry)
Funeral Director		213-09-8228 Usual Residence of Decedent	1 □ M 2004F	88	Yrs.	Months	Days	Hours	Min.	8. Date of Bin (Month, Da Feb • 22	1918		ryland
rylane thow	_	10a. State 10b. Coun	ty	10c. Ci	ty, Town or Le	ocation						1	10d. Inside City Limits
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Mithin he.	mpi	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT us	e retired,)			C&P	സമില	phone Co.
d 2.		17. Father's Name (First, Middle	2 , Last)		Phon	e Ope	Latto.		er's Name	e (First, Middle,	Maiden Sumar		priorie ou
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Example or final barrolling and	To Be	Henry Fis	cher					Ar	na I	Elizabet	th Gerst	ensl	-
Te, Mar 1 and 2 sh Health and tem 27 is m		19a. Informant's Name/Relation Bonnie Suddut			19b. Maili 1221	ng Address Crys	(Street a	nd Numbe Ridge	Rd.	, Marr	r, City or Town, Lottsvi	State, Zip Lle,	MD 21104
Baltimore, permit. Pages 1 a Department of Hes mportant: it item any injury or othe ance.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other	n 3 □Removal from St	20b. F	Place of Disponentery, cre- roll C	osition (Name matory or of remat	ne of ther place ion ,) Inc		3/2006	Hampste	-	own, State Maryland
Baltimol permit. Pages Depertment of important; it is any injury or o		21. Signature of Funeral Service	e Licensee								pel, P.A inster,		1157
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ecords, P	by	Part II. Other significant condi	tions contributing to dea	th but not res	ulting in the u	nderlying ca	luse give	n in Part I.			bacco use cont es 2₽No		ne cause of death?
The The page	Completed	H								24a. Was autop perfor 1 Yes	sy med?	prior to con death?	psy findings available mpletion of cause of
of Vital Physician: This certificat	Be	25. Was case referred to medic examiner?	al Hospital:				Otho		of Death	(Check only o	ne)		
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Vision of the death.	atio	100100111	tigation	Day (ear)	Injury	М		′ ′es 2 🗆 l	No				
- 25:2	Certification:	3 ☐ Suicide 6 ☐ Coule 4 ☐ Homicide deter	minor 200. Place o	f Injury - At h	ome, farm, sti	eet, factory	, office			28f. Location (S City or Tow	treet and Numb n, State)	er or Rura	l Route Number,
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10		30. me and address of person	n who completed cause	of death (Item	1 23a) (Type,	rint)	EC	12	c 1.	EU	115/3	Lin	2/158
Sta Regist		31. Date filed (Month, Day, Yea MAY (strar's Signa		Secreta	,						

			For State Registrar	State of M	larylan		artment of H		Mental Hyg	giene Rog. No.	2006	16287
			Decedent's Name (First, Middle,	Last)					2. Date of Dea Month		Year	3. Time of Death
	Physicia /Medic		Helen A	NICTON	121	e			05	07	2006	, 10:30 Pm
	Examin		4a. Facility Name (If not institution,	give street and number)	١.	4b. City, Town, o	r Location of Dea	ith	4c. C	County of Death	
			CO28121 HOSP	11Ce 24 +1	ne 1	>/e	22/15	If Under 24 Hr		N	71(ON	1100
	Funeral			5. Sex 7. Ag 1 ☐ M 2 💆 F	ge (In yrs. 71	last birthday) Yrs.	If Under 1 Year Months Days	Hours Mir	. (Month, Day	/, Year)	Cou	place (State or Foreign Intry)
	Director		214-68-6159 Usual Residence of Decedent		/ 1				Aug. 31,	1934	4 Ma	ryland
	ylend wow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation	-				10d. Inside City Limits
	Mar.	ģ	MD Wicon	mico	Man	rdela S	Springs					1⊠Yes 2□No
	th the	irec	10e. Street and Number				10f. Zip Code			10g. Citiza	en of What Cou	intry?
	23a (al	510 Charles St	reet			21	.837		U.	S.A.	
	72 hours alter death with the Marylend neturel; or Iteme 23s or 28s-f ehow dicel Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	?	.S. 13. \	Vas Decedent of I f Yes, specify Cub	fispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14	 Race - Amer Black, White 	
20	s afte	by Fi	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 □ Yes 2 23 If Yes, Give Year or Dates:	No		I □ Yes 2 🖾 No	Specify:		5	Specify:	White
2-003	hour		15. Decedent's			16a. Deced	lent's Usual Occup	pation		16b. Kin	d of Business/li	
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<u>a</u>	uld b Ments arked	2	Harold D. Wesl	ey				Oma S	Smith			
<u>a</u>	2 sho and I sm		19a. Informant's Name/Relationshi	nusi	band/		•		Ru <i>ral R</i> oute Numbe			p Code)
2	and ealth m 27		Franklin James	McFarlane	001 5	_		treet N	Mardela S			21837
9	Pages 1 nent of H int: If ited		20a. Method of Disposition 1 Burial 2 □ Cremation 3	3 □Removal from State	20b. F	Place of Dispo	sition (Name of hatory or other pla otist Chu cery	ce)	Date	20c. Loc	ation - City or T	own, State
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paltimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Deperment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene. The Marylen Health and Mental Hygiene Treturel, or Iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Li	CETISEE .		\$1 13	Name and Address Nort Fune E. Grov	ral Home	Delmar, D	E 19	9940	
			23a. Part1. Exter the disease, or c shock, or heart failure. List of	omplications that cause	d the deat	h. Do not ent	er the mode of dyi	ng, such as cardi	ac or respiratory ari	rest,		Approximate Interval Between
. 1	Physician		Immediate Cause (Final disease or condition	Meta	state	is 6	Vovier	Cu	ule			Onset and Death
	/Medical		resulting in death)	Due to (or as	s a conseq	uence of):	P.C					
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	sit 9d	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a conseq	uence of):						
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90	ficate physics the	edical		d								
XO	v requires thet the death certific been signed by the attending p should be detached for use as i	ZW.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			1			23	3d. Date of deliv	re ry
Ď	death e atte d for	Physician/M	in the past-12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pregnanc Other (specify) _	y			Month	Day Year
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,	requires thet the een signed by th hould be detache	by P	Part II. Other significant condition	s contributing to death i	but not res	sulting in the u	ndertying cause giv	en in Part I.	23e. Did to	bacco us	e contribute lo	the cause of death?
Ë	w require been sig should b								1 🗆 Y	es 2	No 3□Pro	bably 4 □Unknown
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Vital	Physician: this certific ral director, i	Be (25. Was case referred to medical examiner?					26. Place of De	eath (Check only of	ne)		
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	ding Phys h. After this funeral di	ü.	27. Manner of Death Natural 5 ☐ Pending		ury ay Year)	28b. Time of Injury	Wo		28d. Describe h	ow injury	occurred	
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\leq	or At after of Direction by	ertification;	4 ☐ Homicide determin	ned 288. Place of In building, e	njury - At no itc. <i>(Specif</i>	ome, tarm, str y)	eet, factory, office		City or Tow	n, State)	Number or Hur	al Route Number,
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Me	29b Signature and title of certifier	0/	,/	7	29c. Licens	se number		29d. Date	signed (Month,	Day, Year)
-	CB		Les I	1.60	/	WAS		0268	778	5	-8-6	26
	Ly.		30. Name and address of person w	no completed cause of	death (Iten	n 23a) (Type,	Print)		278 S-/W/			-3
	10		Dovid E. Corell 1	10 Constal	HU50	ice /	0 Bx 1	733	Solut Y	ns	218	2
	Sta		31. Date filed (Month, Day, Year)	32. Reg ist	rar's Signa	ature			01			
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		State of Maryland / Dep	artment of Health and M	lental Hygiei Reg.	No. 4000 104.00
Physicia	an	1. Decedent's Name (First, Middle, Last) Doris Elizabeth Newsome		2. Date of Death Month May	Day Year 3. Time of Death 8:45 &
/Medic Examin	er	4a. Facility Name (If not institution, give street and number) 130 Millington Road	4b. City, Town, or Location of Death Millington		4c. County of Death Kent
Funeral Director		5. Social Security Number 221-18-9014 0. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 11/06/1	9. Birthplace (State or Foreign Country) 928 PA
Maryland	ctor	10a. State 10b. County 10c. City, Town or L MD Queen Anne's Centres			10d. Inside City Limits 1 May Yes 2 □ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Expirator must be incliffed at once.	by Funeral Director	10e. Street and Number 316 Holly Street 11. Marital Status 1 □ Never Married 2 □ Married 3 【Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 【M No If Yes, Give Year or Dates:	Under the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the spe		Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White
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and 2 should auth and Men 127 is marke		Charlotte Davis/Sister 130	ing Address (Street and Number or Rur) Millington RD	Milling	ton MD 21651
permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other tra once.		1 K Burial 2 Cremation 3 Hemoval from State	osition (Name of ematory or other place) Cemetery 5/1		: Location - City or Town, State hestertown, MD
permit. Departr Importa any inj		1 1 1 I	370 W. Cypress	St Milli	ewnam Funeral Hongton MD 21651
Medical Examiner To use as the burial-transit	cai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fary bearing to amendiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	ome of Li	Ver	3 Mon
0 0 0	Completed by Physician/Medic		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
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sician: The law requires t certificate has been signe rector, page 2 should be a	Complete			24a Was an autopsy performed	
G S. X	To Be	25. Wes case referred to medical examiner? 1 Yes Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing Ho	Check only one) ome 5 Residence	e 6 Other (Specify)
anding bath. or: After he fune	Certification	27. Manner of Death A Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time Injury 28a. Date of Injury 28b. Time Injury 28a. Date of Injury 28b. Time Injury 28b. Time Injury 28b. Time Injury 28b. Time Injury 28c. Place of Injury 28b. Time Injury 28c. Place of Injury 28c. Place of Injury 28c. Place of Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury 28c. Time Injury	Work? M 1 ☐ Yes 2 ☐ No	28f. Location (Stree City or Town, S	at and Number or Rural Route Number,
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To the within 2 To the complet	Me	29b. Signature and title of certifier	D1648		Date signed (Month, Day, Year) 5 - 8- 06
	ate	30. Name and address of person who completed vause of death (Item 23a) (Type 25a). Date filed (Month, Day, Year) 32. Registrar's Signature	hurch Hill Rd	Cheste	ertown m) 216
Regist	rar	MAY 0 9 2008	K breaks		

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) nowottnick Year Physician viartha MAY 6. 2006 :32 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LAPLATA CHARLES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 Ct. | 20, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Увар}937 1 ☐ M 2 💢 F Maryland 68 Yrs 212-34-4083 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No King George Directo Virginia King George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22485 U.S.A. 13443 Poplar Neck Road Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. Iem 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Cashier Food Store or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gertrude Boswell John Franklin Beall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22485 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 nent of Health a Alton E. Pickeral/Friend 13443 Poplar Neck Road, King George, Virginia 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. Trinity Memorial Gdns Waldorf, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 3035 01d Washington Road 21. Signature of Funeral Service Licensee M01391 Huntt Funeral Home POB 156, Waldorf, MD 20604 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician mon the disease or condition resulting in death) una /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. þ Probably 4 □Unknown 1 ☐ Yes 2 ☐ No certificate has been si irector, page 2 should t Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 TYes 2 No Affer this certification Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 No 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Leath 28b. Time of 28d. Describe how injury occurred Natural 2 Accident s after dec. 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medica (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D-46246 ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple M. ASHRAF MEELU, MD / 10 ST.PATRICK'S DR. SUITE 408 WALDORF, MD. 20603 31. Date filed (Month, Day, Year) ∰egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAY 09

2006

Item 29c & Amended Item 30 per Physician 05/09/2006 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylan		artment of F			ene 006	16290
	Physici		1. Decedent's Name (First, Middle, Last) Merrill H. Niner					2. Date of Death		3. Time of Death 2210 M
	/Medic Examin		4a. Facility Name (If not institution, give st Carroll Hospital	·			r Location of Death minster		4c. County of Dea	
	, Funeral ⊩Director		214-32-2729	7. Age (In yrs.	last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day May 08	9. Bir	thplace (State or Foreign buntry) MD
	e Maryland Sa-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County MD Carro		y, Town or Lo Westn	cation ninster				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	23s or 26	rai Dire	3309 Sykesville R	oad		10f. Zip Code 21	157	100	g. Citizen of What Co USA	ountry?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other then "naturel", or Items 23s or 28s-1 ehow or other treumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 XYes 2 □ No 195 If Yes, Give Year or Dates: 195	02	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☎ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036		Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	lent's Usual Occup kind of work done DO NOT use retired (achinist	during most of world)	ring	Black & De	
rland 2	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Herman Niner					e (First, Middle, Ma ide Getti	,	
, Mary	and 2 shorestith and Market 127 is mare or treuma		19a. Informant's Name/Relationship (Typ Joan Niner/wife	e, Print)	1	=		Westmin	City or Town, State, . ster, MD	Zip Code) 21157
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then any injury or other treumatic event. The Meonce.		20a. Method of Disposition 1 ☐ Murial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)		emetery, cren	sition (Name of natory or other place n Memoria	5/10 1 Gardens	,, =000	Finksburg	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service License						apel, P.A inster, M	
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0,	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq						
κ 68760,	sate shy:	Medical	d.							
P.O. Box	that the death certific ed by the attending p detached for use as	Completed by Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3	Ectopic pregnancy Other (specify)	,		23d. Date of dei Month	ivery Day Year
Records, F	w requires that the been signed by th should be detache	ted by P	Part II. Other significant conditions cont	ributing to death but not res	ulting in the ur	HON	en in Part I.	23e. Did toba 1 ☐ Yes		o the cause of death?
al Reco	The law ate has b page 2 si	Comple	D/90e	tes mi	e C (17	-vs		24a. Was an autopsy performe 1 Yes 2	prior to death?	itopsy findings available completion of cause of 2 No
of Vital	Physicien: The lithis certificate har all director, page	To Be	T Tes 22 No		ER/Outpatien		er: 4 🗆 Nursing Ho		ce 6 □Other (Spe	cify)
Division of	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At ho building, etc. (Specifi	28b. Time of Injury	M 1	y at k? Yes 2 □ No	28d. Describe how 28f. Location (Stre City or Town,	et and Number or Ru	ural Route Number,
	Hospitel	Medical Ce	29a. Certifier Check only one) Certifying Physi	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death	occurred at the ting	ne, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the within To the comple	Mec	29b. Signature and title of certifier	ly M)		29c. Licens	4.40	23443 5	1. Date Agned (Month	h, Day, Year)
•	MULA		30. Name and address of person who con	1 1 1 1 1 1 1 1	230) (Mr.)	1130	Baltimore	Blvd.	Vestminste -	er, MD 21157
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 9 2	32. Registrar's Signa		book				

		1	For State Registrar		State of	Marylan		artmer rtifica:			ind M	ental Hy	giene Reg. No	2 (1)	06	162	91
	Physicia	an	1. Decedent's Name (First, Midd.	e, Last)		P.	ARKI	USO,)			2. Date of De	Da O	4 21	Year	3. Time of D	PM
	/Medic Examin	er	4a. Facility Name (If not institution Tive Johns + 5. Social Security Number 217–56–4148	6. Sex	ins 1	tosf 17 Age (In yrs. 56		B	AUT)	Location of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of	e (24 Hrs. Min.	8. Date of Bi (Month, D. Dec. 2	rth ay, Year,	949	9. Birthp	place (State or I ntry) a Scoti	Foreign
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 620 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Leo Joseph Quinlan, Sr. 5 MAY 2006 6:00pm /Medical 4a. Facility Name (If not institution, give street and number)
CIVISTA MEDICAL CEN'I'ER 4b. City, Town, or Location of Death 4c. County of Death Examiner LA PLATA CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Dec. 16, 1934 Wasington D.C. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral **№** M 2□ F 579-44-0698 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or items 23s or 28e-1 show traumstic event, the Medical Examinar mestics notified at 1 ☑ Yes 2 ☐ No Director Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with #2 Fairmont Place 20640 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 3 Widowed 4 Divorced XYes 2 ☐ No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White If Yes, Give Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: #fiem 27 is marked other than * Elementary/Secondary (0-12) College (1-4or 5+) Fire Chief U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Joseph Quinlan Mary Catherine Thoma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 is any injury or other tra Joann Quinlan Wife #2 Fairmont Place, Indian Head, Md. 20640 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🎇 Burial 2 □ Cremation 3 □ Removal from State Chicamuxen United Methodist Church Chicamuxen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. e, or complications that the ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 20640 23a. Part1. Enter the disea shock, or heart failur Approximate Interval Between Onset and Death Immediate Cause (Final Physician ung disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy certificate 1 ☐ Yes 2 Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one ပို Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural Accident 5 Pending death. investigation 1 Yes 2 No completely filled in by the Director 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) terring D-52919 MB UNO leted cause of feath (Item 23a) (Type, Print)
MD 102 CENTENNIAL S of person who comp CENTENNIAL STREET LA PLATA MARYLAND 20646 31. Date filed (Month, Day, Year) MAY 0 9 32. Registrar's Signature State Registrar

		•	For Stete Registrar	State of Marylan			of Health of Deat			iene g. No.2	06	16294
			1. Decedent's Name (First, Middle, Last)	7					2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medic		NANCY AN				RUNKI		MAY		2006	6:30 A. M.
	Examin	er	4a. Facility Name (If not institution, give st FOREST HILL HEALTH		TATION		own, or Locatio REST HII			4c. County HAR	of Death	
	Funeral Director		5. Social Security Number 6. Sex 213-40-1647	7. Age (In yrs.	last birthday). 63 Yrs.	If Under 1 Months	Year If Und Days Hours	er 24 Hrs. Min.	8. Date of Birth (Month, Day, June 2,	Year) 1942	9. Birthp Cour Mar	place (State or Foreign ntry) Yland
	ס		Usual Residence of Decedent									
	show	پ	10a. State 10b. County		y, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	he Ma	ecto	MD Harford 10e. Street and Number	<u> </u>	orest 1	10f. Zip C	`ode		1	0g. Citizen of	What Cour	
	with t	Di	109 Forest Valley I	Ot ino		-	050			USA		,
	ns 23	Funeral Director		2. Was Decedent Ever in U.	.S. 13. V	Vas Decede	nt of Hispanic	Origin? (Spe	ecify Yes or No-	14. Rac		can Indian,
٥	after or Ite	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		res,spec⊪ I⊡Yes 21	y Cuban, Mexid ⊒ k No <i>Speci</i>		nican, etc.)	Specif	ck, White,	
5-003e	hours after death with the Maryland tural; or Items 23a or 28a-f show al Ezatra actitust tectodified at	d by	3X Widowed 4 □ Divorced	Year or Dates:							WIL	ite
'n	n 72 h "natu edica	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Deced (Give	lent's Usual <i>kind</i> o <i>f work</i> DO NOT use	Occupation done during m retired)	ost of worki	ing	16b. Kind of B	usiness/in	dustry
7	filed within 72 Hygiene. other then "nal	фшо	Elementary/Secondary (0-12)	College (1-4or 5+)			Inspec			County	Gove	rnment
aryland 2121	ould be filed of Mental Hygis larked other latic event, the	Be C	17. Father's Name (First, Middle, Last)				18. Mo	ther's Name	(First, Middle, I	Maiden Surnan	n <i>e)</i>	
<u> a</u>	should by nd Menta	ToE	William Herschel Sh	rires					Madron			
	2 sho		19a. Informant's Name/Relationship (Typ						I Route Number			0 Code) 19382
و ف	1 and Health Bm 27 ther tr		Jodie Weaver/daugha		Place of Dispo emetery, cren		0		West Ch	20c. Location		
ğ	Pages nent of l ant: If ite ury or o		1 XBurial 2 Cremation 3 ☐Re '4 ☐Donation 5 ☐Other (Specify)	emoval from State	emetery, cren okview			 05_13	3_2006	Disina	Sun	Maryland
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydiene. Importent: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other treumatic event, the Madical Examinating the multiple at any injury or other treumatic event, the Madical Examination.		21. Sonature of Funeral Service License		The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s						-	me, P.A.
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			23a. Part . Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deat e cause on each line.	h. Do not ent	er the mode	of dying, such	as cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death
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b	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):				7			
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o,	a exec an an irial-tr	Exa	resulting in death) Last	Due to (or as a conseq	uence of):							
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ds, P	es tha gned be de	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying ca	use given in Pa	ırt I.				he cause of death?
Records,	w requir been si should	Completed							24a. Was a	n 24b.	Were auto	opsy findings available
Re	9 - 9	ошр							autops perfor	ned?	death?	ompletion of cause of
Vita	icien: Th certificate ector, pag	BeC	25. Was case referred to medical				26. Pl	ace of Deatl	(Check only on			
of <	dir dir	To	T Tes 2MNO		ER/Outpatier		The second second		me 5 Reside			fy)
		ion:	27. Manner of Death Shatural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	t 28	lc. Injury at Work? 1 ☐ Yes 2		28d. Describe ho	w injury occur	red	
Division	deatl ctor:	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, str fy)	reet, factory,		-	28f. Location (Si City or Town		ber or Rur	al Route Number,
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	2		30. Name and address of person who co DR. DAVID DUNN - 6				E. 106	- BEL	AIR, MI	21014		
		ate	31. Date filed (Month, Day, Year)	32. Registre s Sign	ature #	Los	de					

		•	For State Registrar	State of M	aryland / Dep	artment ertificate			and M		giene Reg. No.	200	6	16295
ì	Physicia	an	Decedent's Name (First, Middle,	,						2. Date of De Month	Day		ar	3. Time of Death
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	e filed within 72 hours after death with the Maryland at Hygiene. other than "natural", or Itema 23a or 28a-1 show vent, the Madical Examinar must be notilised at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar	runde1	10c. City, Town or Crofton	Location							10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
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Maryland 21215-0036	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use h Divis	retired)	, ,			U.S	S. Tre	eası	ırv
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<u>Z</u>	ould b	Tol	Howard Reynold							Carol:				
	es 1 and 2 should be fi of Health and Mental H f Item 27 is marked ot ir other traumatic ever		19a. Informant's Name/Relationshi Carolyn Hamme1-Da							ton, M			te, Zip	Code)
Baltimore,	ages 1 al ant of Hea at: If Item y or othe		20a. Method of Disposition 1X Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp.	3 □Removal from State	20b. Place of Discemetery, cr	oosition (Name ematory or oth	e of er place) !	D	ate	20c. Lo	cation - City		
altii	permit. Pages Department of t Important: If Ite any Injury or of once.		21. Signature of Funeral Service							Linco				
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			23a. Parf. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final)	omplications that cause nly one cause on each f	i the death. Do not e ne.	nter the mode	of dying,	, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Between Onset and Death
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	To the Howithin 24 hours for the Function Completely	Me	29b. Signature and title of certifier		Δ	29c. I	License	number			29d. Date	signed (M	lonth, D	Day, Year)
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2	14)		30. Name and a press of person we Howard K. Schult				Caml	hrill	c M	d 2105/	L			
**	Sta		31. Date filed (Month, Day, Year)	22. Registr	ar's Signature	Bilway	Jaiii	~ 1 1 1 1	.o, 11	4 21036	r			
	Registr	ar	MAY 0 9 20	UD Place	- Marie	December 1								

06-03025 Sasha Crystal Ruiz

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 2006 16296

		I- For State Registrar				Centi	ificate o	t Deati	1				Reg. No.	-	No.	1 0 000
Physicia	ın/	 Decedent's Name (First, Midd 	le,Last)									Date of De Month	ath Day	Year		3 Time of Death
dical Exami	ner	Sasha Cryst	al R	Ruiz							_ N	May 4, 2	006ී	ı cai		1100 hrs
		4a. Facility Name (if not institution	n, give	street and n	umber)			4b. City, T	own, or L	ocation of	Death		4c. C	county of	Death	
		Anne Arundel Medica	l Cent	er				Annar	odlis				Anı	ne Arui	ndel	
Funeral		5. Social Security Number	6. Sex		7. Age (1	In yrs. las	t birthday)	If Unde	r 1 Year	If Under 2	24Hrs. 8	B. Date of 8	irth(MM/DE	(YYYY)	9 Birth	nplace (State or
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any	ŀ	Usual Residence of Decedent 10a. State 10b. County			10	c. City. T	own or Loca	tion								10d. Inside City Limits
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death r ite	Š	1 X Never Married 2 N	arried	1 Yes	2 X	No	"	res, specii	, Ouban,	WICKIGGIT, T	dello reio	san, etc.)		VVIIIC,	CIO.	
after	by F	3 Widowed 4 Div	orced	If Yes, Give Ye	ear		1 X	Yes 2	No	specify:	Mex:	ican	Sp	pecify:	Wh	nite
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215 be fill tral H ked	Be	Enrique E	. Rı	ıiz						Mel	inda	A. E	mert			
21 Suld B	<u></u>	19a. Informant's Name/Relations	hip (Ty	pe, Print)			19b. Mailir	ng Address	(Street	and Numbe	er or Rura	al Route N	ımber, City	or Town,	State,	Zip Code)
AD 2 sho 27 is	٠	Enrique E. Ru	iz/	Fathe	r		6174	Fish	ers	Stati	on R	d., I	o thia	in, M	1D 2	:0711
ore, MD 21215-0036 us 1 and 2 should be filed within 72 of Health and Mental Hygiene. If item 27 is marked other than " ther transmatic event, the Medical		20a. Method of Disposition					ace of Dispo		e of cem	etery,	D	ate	20c. Lo	cation - C	City or T	Town, State
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timen trans		4 Donation 5 Other S 21. Signature of Funeral Service				Our	Lady	Name and			5-8-					, MD
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other transmatic event, the Medical Examiner must be notified at once		21. Signatura of Funeral Service	Licens	ee												al Home
	_	23a. Part I. Enter the disease, o	compli	cations that	caused the	o death [20 not enter	the mode of	OLOM	ons 1	Stan	a Ra	rest shock	:Wate	er,	MD 21037 Approximate Interval
Physician /Medical		failure List only one cause			causeu III	e dealii. L	Jo not enter	the mode t	i uying, s	ucii as cai	ulac of Te	sspiratory a	rrest, sriock	, or riear	`	Between Onset and
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		or condition resulting in death)		ue to (or as	a consequ	uence of):									- 1	
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8760, tificate b ng physic as the bur	Mec	IF FEMALE:		23c. If yes	outcome	of pregna	ancy						23d. I	Date of d	lelivery	
rtific		23b. Was decedent pregnant in past 12 months?	he	1 Live			_	etal death	3	Ectopic p	pregnancy	у	М	lonth	Da	ay Year
ox (ici	1 Yes 2 No 9 ✔ Ur	known		gnant at tin	ne of dea	th 5 C	ther (Spec	cify)							
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ires that the signed by 1 be detached	by P	Part II. Other significant cond	tions	contributing	to death b	out not res	sulting in the	underlying	cause gir	ven in Part	: I.			_	_	he cause of death?
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		30. Name and address of person	r who c	ompleted ca	use of dea	ath (Item 2	23a)			-						
				ant Medic			111 Pen	n Street	Baltim	ore, MD	21201					
S	tate	31. Date filed (Month, Day, Year	2	32/	Registrar's	Signatyr	е									
Regis		MAVA	3 20	06	Mar.	10	100	W								
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State of Maryland / Department of Health and Mental Hygiene? 11 11 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician Gerald J. Razler 2006 Mav 6:30 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cecil Island Road Earleville 645 Knight If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 2 M 2 □ F 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 83 Yrs. 183-14-2577 10/25/1922 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "naturel", or Items 23a or 28e-f show Ite Medical Examiner i ust be notified at 1 ☐ Yes 2 ▼No Director Cecil Earleville MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21919 USA 645 Knight Island Road Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1☐ Yes 2XNo Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail Engineer other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth-any injury or other treumatic event. 17. Father's Name (First, Middle, Last) Bruno Razler Helen Fizur 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catherine Razler/Wife PO Box 534 Ceceilton MD 21913 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 5/19/06 ¹ 4 □ Donation 5 □ Other (Specify) Our Lady of Grace Philadelphia PA 21. Signature of Funeral Service Licensee Fellows, Helfenbein & Newnam F. 370 W. Cypress St Millington MD shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility H 21651 Approximate
Interval Between
Onset and Death

6 months Immediate Cause (Final disease or condition resulting in death) Pancrestic Physician Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the crying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): -transit and Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. Il yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. δ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 A No Division of Vital I or Attending Physician: after death. Director: After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel or within 24 hours afte To the Funerel Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 10, 2006 grate: completed cause of death (Item 23a) (Type, Print) Hospice, ElkTon, Sassons -arkes 31. Date filed (Month, Day, Year) 32. Registra 's Signature State Registrar

Physician /Medical Examiner

burial-fransil

or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Examiner

Physician/Medicai

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Certification: To Be Completed

Medical

. Pages 1 and 2 should be filed v tment of Health and Menfal Hygie tant: If Item 27 is marked other t jury or other traumatic event, the

permif. Pages 1 Department of H Important: If ite any injury or ot once.

Maryland

Baltimore,

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show

Completed by Funeral Director

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24a. Was an

25. Was case referred to medical examiner?

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

autopsy performed? 2 110 1 Yes 26. Place of Death Check only one

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1 ☐ Yes 2 ☐ No 27. Manner of Death

4 THomicide

1 ANatural 5 Pending investigation 2 Accident 6 Could not be 3 T Suicide

28a. Date of Injury (Month, Day Year)

and manner stated.

Other: 4 Nursing Home 5 Residence 6 Definer (Specify) 455 15750 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

-out

29c. License number A (3017 29d. Date signed (Month, Day, Year) MAY, 13, 2006

21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

340 MILLST HAGERSTOWN DATTAMD

Registrar

31. Date filed (Month, Day, Year) 2006



s effer del... ral Director: Alte

To the Hospital o within 24 hours eft To the Funeral Di completely filled in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM# 10c rjw State of Maryland / Department of Health a 05/19/ $\frac{1}{6}$ State Cecil Co. Health Dept Certificate of Death State of Maryland / Department of Health and Mental Hygiene) Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 5.20 2000 nounts /Medical 4c. County of Death 4b. City, Town, or Location of Death Name (If not institution, give street and number) Examiner 5. Social Security Number Baltimore City HUY 7. Age (In yrs. last birthday, If Under Months 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours 1 ☐ M 2 💢 F 80 Yrs. Director 171-20-6719 Nov. 8. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director New Providence Lancaster Washington Boro the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3032 Miller Road 17582 USA Ітет 23а Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 X Widowed 4 □ Divorced 'naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 7. Ind Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mfg. Glass Factory 8 Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fi and Mental H Charles J. Morrison Myrtle V. Frank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) is 1 and 2 s of Health an item 27 Is I Connie Rice/daughter 204 Landis Valley Rd., Lititz, PA 17543 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 05-13-2006 permit. Pages Department of Importent: If it eny injury or o 1 XBurial 2 Cremation 3 X Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Millersville Mennonite Cemetery Millersville, PA 21. signature of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician UNE MELIMONIA /Medical Due to (**Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit be executed FAILURE Due to (or as a consequence of) Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) _ P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown ADENOCALC: NOMA. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Congenital autopsy performed 1 ☐ Yes 2 ☐ No Hux aas moesophagen 2 No 25. s case referred to me ical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 \(\tag{Nursing Home} \) 5 \(\tag{Residence} \) 6 \(\tag{Other (Specify)} \) 1 ☐ Yes 2 ♠No 1. Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Beth FroyD, MD Mιl 32. Segistrar's Signatu State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle, Last) 2. Date of Death Month Day Year **Physician** 05:36 AM 8 LAWRENCE JOHN SIFEL MAY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CALVERT CALVERT MEMORIAL HOSPITAL PRINCE FREDERICK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 XM 2 ☐ F Months Hours Director MARYLAND 58 1948 218-44-8778 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d Inside City Limits 10a State 10b. County itame 23a or 28a-f ehow mer rest be netified at 1 Yes 2 No Directo MD ST. MARY'S **MECHANICSVILLE** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 27550 WOODBURN HILL ROAD 20659 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 🛣 No Specify Ā the Madical Exa 3 Widowed 4 Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 LUTHIER GUITAR MANUFACTURING other 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be IRENE KRALIK JOHN SIFEL ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27550 WOODBURN HILL RD. MECHANICSVILLE, MD 20659 Health tem 27 i JEAN R. SIFEL / WIFE item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BRINSFIELD-ECHOLS CR.MAY 10,2006 CHARLOTTE HALL, MD 22. Name and Address of Facility BRINSFIELD-ECHOLS FUNL.HME., P.A. 21. Signatu)e of Funeral Service Licensee Deper impor any in MOO641 30195 THREE NOTCH RD. CHARLOTTE HALL, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCAL HOUX C **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) P.O. I 9 ☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Tyes 2 No 3 Probably 4 Dunknown certificete has been s rector, page 2 should Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 ¥Yes 2 □ No 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred t Natural 5 Pending death. 1 Tes 2 No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funerei Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 5 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MAY 8, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHILIP WISOTSKY, M.D. 12070 OLD LINE CENTER #207 WALDORF, MARYLAND 20602-2567 32. Bigistrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 0 2006 Goard ! Registrar

Mary Theresa Spencer

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

,		For State egistrar	Certifi	cate of L			Reg	No. 20	04 1496
Physician Medical Examine	1	. Decedent's Name (First, Middle,Last)	SPENCER		_	_	2. Date of Death Month D	ay Year	3. Time of Death
neulcai Examine		MARY THERESA la. Facility Name (if not institution, give stree		4b.	City, Town, or	Location of Death	May 15, 200	4c. County of Dea	
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Funeral Director	-	5. Social Security Number 6. Sex	7. Age (In yrs. last b		If Under 1 Yea Months Days		1	MM/DD/YYYY) 9. I	eignMARYLAND
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7 P 8 8 5	╩├	9a. Informant's Name/Relationship (Type, P							ate, Zip Code)20743
C 02 5 74	L	SHEILIA SPENCER/DA 20a. Method of Disposition			ey Wort			Heights,	
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Baltimore, permit. Pages 1 a Department of He Important: If ite	-	4 Donation 5 Other Specify: 21. Signature of Fundar Service Licensee	RESU		ON CEME			CLINTON, INS FUNER	
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Sox 687 leath certifi e attending for use as t	clan	past 12 months?	Live birth Pregnant at time of death		death 3 r (Specify)	Ectopic pregna	incy	Month	Day Year
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P.O. s that the med by detach	의	Part II. Other significant conditions contri	buting to death but not resul	ting in the und	lerlying cause (given in Part I.			to the cause of death?
Division of Vital Records, P.O. rate or Attending Physician: The law requires that it is after death. The law requires that the artificate aboven signed by all Director: After this certificate aboven signed by the funeral director, page 2 should be detailed in the funeral director, page 2 should be detailed.	Completed						24a. Was an		autopsy findings available
Recor The law icate has be	ğ						autopsy perform 1 V Yes 2	ed? death	
ital Redician: The scertificate rector, page	انت	25. Was case referred to medical			26.Place	of Death (Check			765 2 116
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Division Hospital or Attent 24 hours after death Funeral Director: stely filled in by the	() H	4 Homicide determined	Specify) Apartment				Apt 303 Se	at Pleasant	Rural Route Number, City g Street , MD
9 C = - '	ledical ((Crieck Only	the best of my knowledge, to basis of examination and/o						
To the within 2 To the complet	Med		manner stated		29c Licens			29d. Date signed (M	
		anote -			O.C.	M.E.		May 16, 2006	
CIRTI		30. Name and address of person who comple			not Dalaise	ore MD 2420			
Sta	te	Ana Rubio MD. Assistant Me 31. Date filed (Month, Day, Year)	2. Registrar's Signature			ore, MD 2120			
Sta Registr		MAY 1 7 2006	Mary K	book	•				

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician 2006 10:50 p M Schmidt Elizabeth May /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Health & Rehab. Annapolis Anne Arundel 8. Date of Birth (Month, Day, May 29, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛱 F 1924 Director 217-12-7973 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show r items 23a or 28a-f shov iner must be notified at 1 ☐ Yes 2 ₩ X Director Anne Arundel Annapolis the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 532 Coover Road 21401 USA death 1 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. and if item 27 is marked other then "naturel; or flee ury or other treumatic event, the Mentalizal Essuring ury or other treumatic event, the Mentalizal Essuring ury or other treumatic event, the Mentalizal Essuring. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 White Specify 3₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Rhebs Candies 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas Perry Mary Magee ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 712 Black Forest Road, Annapolis, MD 21409 Darlene Mallick (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition tment of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if ony injury or once. 5-8-2006 * 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cem. Elkridge, MD 21. Signature of Funeral Service 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and De Immediate Cause (Final disease or condition resulting in death) **Physician** Melasialil /Medical Due to (or as a consequence ol) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed physicien ar Due to (or as a consequence of) Box 68760. Physician/Medical as the attending IF FFMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. P 9 Unknown signed by 1 d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 2 No 1 🗌 Yes 3 Probably 4 Unknown should should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No this certificate has page 1 🗌 Yes or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 Inpatient Other: 4 Wursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No ٩ 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Aatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel Medical 🛮 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific

State Registrar

31. Date filed (Month, Day, Year) MAY 0 8 2006

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e and address of person who completed cause of death (Item 23a) (Type, Print)



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State of Maryland / Department of Health and Mental Hygiene) For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY 5, 2006 **Physician** CHARLES WILLIAM SLAGLE 18:30 p M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENT 866 WASHINGTON AVE. CHESTERTOWN If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign FEBRUARY 28, 1922 MD 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1X M 2□ F Months 84 215-12-6204 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Director MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 866 WASHINGTON AVE. 21620 USA 23a by Funeral death 12. Was Decedent Ever in U.S. Armed Forces?1 XYes 2 ☐ No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married ō WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☒ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) CARPENTER WOODWORK othar traumatic avant. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental ant; If itam 27 is marked o CHARLES P. SLAGLE SARAH DICKERSON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHY CHANCE/DAUGHTER P.O. BOX 266, ROCK HALL, MD 21661 Important: If itam any injury or othan 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
CHESAPEAKE CREMATORY 1 Burial 2 Cremation 3 Removal from State 05/08/2006 STEVENSVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFEN 130 SPEER ROAD, S OF FACILITY HELFENBEIN BEIN AND NEWNAM FUNERAL HOME CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or complication, that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, Approximate Immediate Cause (Final Pnysician CIY disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attanding Physician: The law requires that the death certificate be executed nding physician and use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has lirector, page 2 s 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 1 🗌 Yes 4 ☐ Nursing Home Residence 6 Other (Specify) Certification; To this 28d. escribe how injury occurred 28c. Injury at Work? 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Diractor: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide within 24 hours at To tha Funaral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier 0 use of death (Item 23a) (Type, Print) Name and address of person who completed o 1 Sen D M min

State

Registrar

31. Date filed (Month, Day, Year)

32. Regisar's Signature

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			For State Registrar	9	State of M	1aryland		artmen rtificat			and M	lental Hy	giene	006	16	304
	Physici	an	1. Decedent's Name (First, Middle CH RIS TOPHE)		PE	FTER		T.	hon	MAS	3	2. Date of De Month	ath Day	Z. Put	3. Time 23	-
	/Medio Examir	er	4a. Facility Name (If not institution Anne Arundel	n, give stre	al Cen	ter		Ann	apo1				Aı	ounty of Deat	ınde1	
×2	Funeral Director		5. Social Security Number 579-62-5542 Usual Residence of Decedent	6. Sex	7. A	46	ast birthday, Yrs.	Months Months	Days	If Under Hours	Min.	8. Date of Bin (Month, Da Aug. 25	v. Year)	Co	nplace (State untry) shingte	or Foreign
	he Maryland Be-f ahow cuffied at	ector	10a. State 10b. County MD Anne	Aruı	ndel		, Town or L	lis	Cada				10a Citiza	n of What Co		City Limits
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or iteme 23e or 28e-f ahow event, the Medical Exeminar must be notified at	eted by Funeral Director	10e. Street and Number 4 Carriage Run 11. Marital Status 1 Never Married 2 Ma. 3 Widowed 4 Divorce 15. Decede (Specify only high	ned d	Was Deceder Armed Force: 1 ☐ Yes X If Yes, Give Year or Dates	s? Y No	16a. Dece	1 Yes	214 dent of Hi cify Cuba XX No	spanic Ori n, Mexicar Specify: ation		ecify Yes or No Rican, etc.)	- 14 s	JSA Race - Ame Black, White pecify:	ncan Indian, a, etc. White	
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ore, Maryland	ss 1 and 2 sho of Health and Item 27 Is m	F	19a. Informant's Name/Relation Lindsey E. Tho 20a. Method of Disposition 1 □ Burial 2 【▼Cremation	ship (Type mas ((Wife)			arria	ge R	un Co	urt;	al Route Numb Annapo Date	olis,		03	
Baltimore,	permit. Pages Department of I Importent: if Its any injury or o once.		4 Donation 5 Other (Specity)	\		ro Cr	2. Name a Hard	nd Addres	s of Facilit	al F	2006 Iome, P.	Α.	more,	Vovorež	
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8760,	cate be executed physician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ر. م	,	as a consequas a consequ	,									
O. Box 6	The law requires thet the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	230	. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	□Ectopic p		54			23	d. Date of del Month	very Day	Year
Records, P.	aw requires thet s been signed b 2 should be dett	Completed by Pl	Pan II. Other significant condit	ions contr	buting to death	but not resu	ulting in the	inderlying in the second	cause giv	en in Part I	·	1 🗆	Yes 2	24b. Were au	obably 4 [Unknown
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Division of	ding Phys After this funeral di	cation; To	Z Accident	ing tigation	28a. Date of li (Month, I	njury Day Year)	ER/Outpatie 28b. Time Injury	of M	28c. Injur Wor 1	4 [] INI		ome 5 Resi 28d. Describe	how injury	occurred		
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)	To the Hos within 24 h To the Fur completely	Medical	(Check only		r: On the basis and manner		Az un	29	c. Licens	e number	/2	red at the time,	29d. Date	signed (Monta	n, Day, Year,	
			30. Name and address of person Michael	alien	1-4 11	of death (Item		, Print) EFEN	SE,	It G	# W	in A	NNA	2045/	40214	(0/
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DHMH 17 Rev 1/2001

Registrar

06-02936

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene Monico Bernice Thompson

2006 16305

		1- For State Registrar	Cert	ificate o	f Death		Re	eg. No.	00 1000
Physici	an/	Decedent's Name (First, Middle,La	st)				Date of Deat Month	h Day Year	3. Time of Death
ledical Exami		Monico	Bernice		Thom		May 1, 200	06	1125 hrs
	6-	4a. Facility Name (if not institution, gith Hawthrone Road at Bibur			4b. City, Town, or La Plata	ocation of Deat	h	4c. County of E	Jeath
_ مدید		Social Security Number 6. S	<u> </u>	et hirthday)	If Under 1 Year	If Under 24Hr	s 8 Date of Bird		9. Birthplace (State or
Funeral Director			M 2xF 43	Yr:	Months Days	Hours Mi	1		oreign Marylan
*		Usual Residence of Decedent	40- 03- 7	own or Loca	tion				10d. Inside City Limits
w any		10a. State 10b. County				_			1 X Yes 2 No
faryland 28a-f show 1 at once.	ģ	MD Charl 10e Street and Number	es	Ind	ian Hea	<u>id</u>	140	og. Citizen of What	
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eath w items ust be	Funeral	1 Never Married 2 Marrie	d Armed Forces?		Yes, specify Cuban,			White, e	etc.
her de ", or er mu		3 Widowed 4 X Divorce	1 Yes 2 No	1	Yes 2X No	specify:		Specify: B	lack
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygens 7 is marked other than "natural", or items 23a or 28a-f8he matic event, the Medical Examiner must be notified at once	d by	15. Decedent's Education (Specify	only highest grade completed)		nt's Usual Occupatio			16b. Kind of Busin	ess/Industry
5 72 hc nn "na sal Ex	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)		nost of working life. [tirea)		
003(vithin ene er tha Medic	dm	12]	Homemake			Dome	stic
15-C	ပ	17. Father's Name (First, Middle, Las	,				, , ,	Maiden Surname)	
21215-0036 uld be filed within? Mental Hygiene marked other that	To Be	Maxwell 19a Informant's Name/Relationship (Thomps		ng Address (Street	Annie	T.	Proc	
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al al al al		20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of cem-		Date	20c. Location - Ci	ity or Town, State
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Physician		23a: Part I. Enter the disease, or comfailure. List only one cause on	plications that caused the death. I	Do not enter	the mode of dying, s	such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical			Multiple Injuries						Death
Examiner		or condition resulting in death)	Due to (or as a consequence of)	:					
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ti d	Examiner	events resulting in death) Last	Due to (or as a consequence of)	:					
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x 68 h cert tendir	icia	past 12 months?	4 Pregnant at time of dea	th	ther (Specify)		,		,
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Division of Vital Records, tat or Attending Physician: The law requirers after death and Jorector. After this certificate has been seled in by the funeral director, page 2 should also have been a been be been a been be been a been be been a been be been and the present beautificate by the funeral director, page 2 should be a because the beautificate by the formeral director.	ompleted						autop	sy prio	ere autopsy findings available or to completion of cause of ath?
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Hospital 24 hours Funeral tely filled	0	4 Homicide 29a. Certifier 1 Certifying Physi	cian: To the best of my knowledge			e and place ar			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only	er: On the basis of examination an						
To To con	Mec	296. Signature and title of certifier	and manner stated		29c. License	number		29d. Date signed	(Month, Day, Year)
	1	() a la lo 100			O.C.N	1.E.		May 2, 2006	
	1	30 Name and address of person wh	o completed cause of death (Item 2	23a)					
NB2.		Laron Locke MD. Assi	stant Medical Examiner		n Street, Baltim	ore, MD 21	201		
S	tate		2006 32. egistrar's Signatur	E 1	- 00				
Regis	strar								

		•	1 _ State	epartment of Health and M Certificate of Death	-	ene a. No. 2 0 0 1	5 16306
10			Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		Gloria Jean Taylor		MAY 5.	Day Ye 2006	8:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of E	
		.,	CIVISTA MEDICAL CENTER	LAPLATA		CHARLES	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
Z.	Director		577-34-2740 1 M 2 X 77 Usual Residence of Decedent	frs.	March 1	6,1929	Washington DC
	land ow Lt		10a. State 10b. County 10c. City, Town	or Location			10d. tnside City Limits
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	r 28s	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of Wha	Country?
	th wit		7 Kenwood Place	20640		U.S.A.	
	r dea	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican fndian, /hite, etc.
36	or It	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ YNo II Yes, Give 9 Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify:	White
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212	d with	E O		ministrative Tech.	U	.S. Gove	rnment
Maryland 21215-0036	buid be filed within 72 hours after death with the Maryland Mental Hygiene. arked other then "natural; or Items 23a or 28a-f show arked other then "natural; or Items 21a or 28a-f show afte event, It a Medical Examinar must be notified at	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M	aiden Sumame)	
yla	Ment Ment mrke attc	2	Joseph W. Rye		Christee		· · · ·
Jar	2 sh and Is m			Mailing Address (Street and Number or Run			
	1 and 1eelth om 27 ther t			90 Woodcox Rd., Indi		Oc. Location - City	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: if item 27 is marked other then "natural; or items 23a or 28a-1 show any injury or other traumatic event, it a Medical Examinat must be notified at ADEs.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	y, crematory or other place) May 11.	2006		
ᆵ	it. Partmer intmer injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens →	y Menorial Gardens		Waldori,	Maryland
Ba	Department of the partment of			Williams Funeral Ho	me, P.A.	** 7 .4	3 20640
* 765 G			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	int enter the mode of dying, such as cardiac	or respiratory arres	Head, M	d. 20640 Approximate Intervat Between
	Physician		Immediate Cause (Final	in			Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of	of):			
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8760,	icate be executed physician and s the burial-transit	al E	Due to (or as a consequence of	1.7.			
		dical	d			9	
× 6	The law requires that the death certificate has been signed by the attending to	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of	delivery
Вох	death atter	ciar	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
P.0.	t the c by the ached	hysi	9 Unknown				
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ğ	aquire en siç ould b	ed	Chronic obstructive Pal	mowany Disease	2 1 ☐ Yes	2 □ No 3 €	Probably 4 Unknown
of Vital Records,	has be	Completed	TOBACCO USE		24a. Was an autopsy		autopsy findings available to completion of cause of
<u> </u>	The ete h pege	Son			perform	ed/ deat	
/ita	ilcian: Th certificete rector, peg	Be	25. Was case referred to medical examiner?		h (Check only one		
of 0	Physician: this certifical director,	5	1 ☐ Yes 2 No Hospital: 1 Unpatient 2 ☐ ER/Ou 27. Manney of Death 28a. Date of Injury 28b. T		ome 5 Resider		Specify)
n	ding I	ion	1 12 Natural 5 □ Pending (Month, Day Year) fr	ime of 28c. Injury at Work? M 1 Yes 2 No	200. Describe nov	v intery occurred	
Division	f or Attending after death. Director: After in by the fune	ficat	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, fa		28f. Location (Stre	et and Number o	Rural Route Number,
<u>S</u>	after after Direct	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: To the best of my knowledge	, death occurred at the time, date and place,	and due to the cau	use(s) and manne	r as stated.
	in 24 he Fu he Fu pletel	edicai	(Check only 2 Medical Examiner: On the basis of examination and manner stated.				
	To t com	Σ	29b. Signature and title of certifier	29c. License number	29	d. Date signed (M	
_			- Xunty u	D-0054044		5/6/	2006
1	217		30. Name and address of person who completed cause of death (Item 23a) (
	17) 1/		LINDA A. JEFFERSON, MD 2670 CRAI		20601		
(4°	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 9 2006	Goods)			

to me

	1 = For State Registrar	State of Maryland /	Certificate of D	eaim and M Death		g. No.	1530
hysician /Medical	Decedent's Name (First, Middle, L Sam	williams			2. Date of Death Month	29 06	3. Time of Death 6:50 P.M
xaminer	4a. Facility Name (If not institution, g 7903 Indian I	lead Hwy	4b. City, Town, or Oxon I	Hill		4c. County of Death Prince G	
neral ector	370-32-3401	Sex 12 Age (In yrs. last bit 7 2 7 2	rthday) If Under 1 Year Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, 1	Yeer) 9. Birthy 33 So.	olace (State or Foreign Carolina
iffed at	Usuel Residence of Decedent 10a. State 10b. County MD Prince	Georges Oxor	n or Location Hill				10d. Inside City Limit
l'rec	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	ntry?
tien 27 is marked other than "natural, or flems 23s or 23s-1 show other traumatic event, the Madical Examinat "sust be notified at To Be Completed by Funeral Director	7903 Indian He 11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No	20745 13. Was Decedent of His If Yes, specify Cubar 1 Yes 2 No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	USA 14. Race - Americ Black, White, Specify: P1	
natural, o edical Exar leted by	3 Widowed 4 Divorced 15. Decedent's (Specify only highest g	Education 16a	Decedent's Usual Occupa (Give kind of work done di life, DO NOT use retired)	uring most of worki	ing	6b. Kind of Business/In	
vent, the Medical Se Completed	Elementary/Secondary (0-12) 6th 17. Father's Name (First, Middle, La	College (1-4or 5+)	Supply	Manager 18. Mother's Name		Federal G	ovt.
raumatic even	Nathanial Wi	liams	b. Mailing Address (Street a	Grace (City or Town. State. Zir	Codel _
or trau	Thelma Willia	ams/spouse	7903 India	n Head E	Iwy #30	0 Oxon Hi	11, MD
any injury or other tra	20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Specific Specific oval from State cemete	of Disposition (Name of ery, crematory or other place tico Cemete	3)		Triangle,		
eny inje	21. Signature of Funeral ServicerLic	Alense MO1178	22. Name and Addres BK Henry 420 H Str	s of Facility Funeral eet NE	Chapel Washing	Inc.	0002
ician dical	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	Pneumoni:	not enter the mode of dying	g, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
niner ੋਂ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	Mellitus 1	II			
s the burial-transit	resulting in death) Last	c. Hyperten: Due to (or as a consequence					
be detached for use as it by Physician/Med		23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown	h 3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deliv Month	ery Day Year
should be deta	Part II. Other significent conditions	contributing to death but not resulting	in the underlying cause give	on in Part I.		accoluse contribute to t	
m p					24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of
ertifi ector Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DOA Othe	N2+	h (Check only one	nce 6 Other (Specia	4.1
After this o funeral dire		28a. Date of Injury (Month, Day Yeer) 28b.	Time of linjury Work		28d. Describe hov	-	9)
ed in by the funera	3 Suicide 6 Could no 4 Homicide determin	be 380 Place of Injury - At home	farm, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
completely filled in by the fu		Physician: To the best of my knowledgaminer: On the basis of examination a and manner stated.					
сошр	29b. Signature and title of certifier		29c. License		/	d. Date signed (Month,	
		o completed cause of death (Item 23a) (Type, Print)	35743	196012	J	2006
		Whang, MD 610	04 Old Bran	-1- 7	// manual 1 a	** 1 0 0 3 55	20740

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** WARE April 30, 2006 0800 ROSA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges Capitol Heights 1016 Minna Ave. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 16,1922 Wash. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🔀 F D.C. 83 Director 579-20-2275 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County **ehow** Items 23a or 28e-f ehov 1√2 Yes 2 No Director Washington D.C. 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20009 1432 R. Street, N.W. #201 death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status traumatic event, the Medical Examiner: Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Iter any injury or other traumatic. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: **Black** φ 3 to Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Government Domestic 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emily Berry Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1016 Minna Ave. Capitol Heights Md. 20743 Theresa Bowlding/Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ty⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 5/4/06 Landover, Md. 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Pk 22. Name and Address of Facility Johnson & Jenkins Inc. 21. Signature of Funeral Service Licensee 716 Kennedy St., N.W. Wash. D.C.20011 23a. Part1. Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Breast Carcinoma Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the buriat-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Hypertensive Cardivascular Disease, Diabetes Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes XXX No 24a. Was an Mellitus Aortic Stenosis Debility has performed? 1 ☐ Yes XX No 2€ No Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Daughters Other: $_{4}$ Nursing Home $_{5}$ Residence $_{6}$ Other (Specify) Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🛣 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 5 Pending 1 X Natural s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours aff To tha Funeral Di completely filled in To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of cert MD30564 May3, 2006 30. Name and addres of person who completed cause of death (Item 23a) (Type, Print) Anthony Ibe, M.D. 1160 Varnum St., N.E. Suite 106 Wash D.C. 20017 31. Date filed (Month, Day, Year) State MAY 0 9 2006 Registrar

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

Pamela Warren 1- For State Certificate of Death Rea No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day 4, 2006 Pamela Jane Warren 1650 hrs **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's 5015 60th Avenue Bladensburg 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or if Under 1 Year If Under 24Hrs Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign 577-60-9363 Months Davs Director 4/30/1946 Country) Europe 1 M 2 XF 60 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 X Yes 2 No **Bladensburg** Prince George's 28a-f show filed within 72 hours after death with the Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 28a-20710 United States 5015 60th Avenue Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married 2 X No Yes 3 X Widowed f Yes, Give Year 4 Divorced 1 Yes 2 No specify: Specify: **Black** 5 r Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) JOFC, m.c. ages I and 2 should be filed within 72 nor ages I and 2 should be filed within 72 nor not of Health and Mental Pygene ntt. If item 27 is marked other than "ns remnantic event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Administrative Supervisor 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eller Maxwell William Lassery Be 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5015 60th. Avenue Bladensburg, MD 20710 Steven Lassery (Son) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place Burial 2 X Cremation 3 Removal from State Fort Lincoln Crematory 5/11/2006 Brentwood, MD tment o Important; Donation 5 Other Specify 22. Name and Address of Facility Fort Lincoln Funeral 1 3401 Bladensburg Road Brentwood, MD 21. Signature of Funeral Service Licensee DHome D20722 whow complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a. Pulmonary Thromboembolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Left leg deep vein thrombosis Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner c. Left foot fracture cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical UNPENDED AMENDED sician physician the burial Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 🗸 Unknown Unknown should be detached 23e Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed Records, peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has l death? performed? Yes 2 1 🗸 Yes After this certificate To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 V DOA Nursing Home 5 Residence 6 1 V Yes 28a. Date of Injury (Month, Day, Year) Unknown funeral 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Subject injured left foot Certification Unknown Natural 1 Yes 2 ✓ No Pendina the f 2 🗸 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 5015 60th Avenue, Bladensburg, MD (Specify) unknown Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started **Medical** (Check only 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E May 5, 2006 30. Name and address of person who amplet cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) State Registrar ORIGINAL

		For State Registrar		State o	f Maryla	and / Dep Ce		nt of F ate of			ental Hy	/giene Reg. No.	a UU	6	15310
Physicia /Medic		1. Decedent's Name James	(First, Middle, L L •	^{ast)} Wrigh	t, Sr						2. Date of D. May	eath 3 ^a y	200	16	3. Time of Death 5:58 P M
Examin	_	4a. Facility Name (If I Holy Cross 5. Social Security Num	s Hosp	ital Sex	7. Age (In y	rs. last birthdaj	Silv	y, Town, o yer Sj der 1 Year s Days	pring	er 24 Hrs.	8. Date of B	Mo	ntgome	ry	ice (State or Foreign
Director		577-70-318 Usual Residence of D		1 X M 2□F	54	Yrs.		S Days	riodis	IVIII.	11/24/	1951	W		ington, Do
Marylan -f ehow Lied al	tor		10b.County Prince	George's		City, Town or I Linton	Location							10	d. Inside City Limits
with the a or 28a	Direc	10e. Street and Numl	per			7.0		Zip Code					zen of What nited		_
ie; intally land Z IZIOCOOO s 1 and 2 should be filed within 72 hours after death with the Maryland ff Health and Mental Hygiene. If the Armarked other then "natural", or Iteme 23s or 28s-f show other traumatic event, the Mattical Examination at the multified.	by Funeral Director	12706 Pi. 11. Marital Status 1 Never Marrier 3 Widowed 4	d 2 Married	12. Was Dece Armed Fo	edent Ever in orces? 2 7 No		. Was Dec		lispanic C an, Mexic Specif		cify Yes or N Rican, etc.)		14. Race - A Black, W Specify:	merica	n Indian,
within 72 housing.	Completed	(Specify		Education trade completed) College (1	1-4or 5+)			sual Occup work done use retired Hand		ost of workin	ng		nd of Busine		
Id be filed vental Hygic	To Be Co	17. Father's Name (F		st)							(First, Middle tewart		Surname)		
nd 2 shoulth and M. 27 le mart		19a. Informant's Nar	ne/Relationship		ouse)	1	-						r Town, State		
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny Injury or other tra		20a. Method of Dispo	sition Cremation 3	☐Removal from	201	o. Place of Disposers, cr cernetery, cr ort Lin	.coln	Ceme	tery	5/8/2		Bre	ntwood	1, N	ÍD .
permit. Departmit. Importa eny inju		21. Signature of Fun	eral Service Lio	enso						ility For			Funera od, MI		
Crate be executed Physician and Physician and physician and sthe burial-transit	dicai Examiner	23a. Part. Inter the shock, or heart Immediate Cause (F disease or condition resulting in death) Sequentially list condition in the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the sh	failure. List on inal ditions, rediate ying along	y one cause on e Sep a	osis (or as a consingesti	sequence of): ve Hear sequence of):				is cardiac o	respiratory	arrest,			Approximate interval Between Onset and Death
Attending Physician: The law requires that the death certificate be executed actions. The law requires that the death certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 n 1 □ Yes 2 □ 9 □ Unknown	nonths?		oirth 2 ☐ F nant at time o	etal death 3	t⊡Ectopid i □ Other	pregnancy (specify)	/				23d. Date of Month		y Day Year
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The law required has been page 2 shou	Completed						<u>. </u>				perl	s an opsy formed? 2 X No	24b. Were prior death	to com	sy findings available pletion of cause of
VILA ician: certific ector,	Be	25. Was case referre		Hospital: 1				DOA Oth			(Check only				
To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2.	tion: To	1 ☐ Yes 2 🔯 N 27. Manner of Death 1 📆 Natural 2 ☐ Accident	5 Pending investigat	28a. Date (Mon	Inpatient 2 of Injury oth, Day Year	2 ER/Outpati 28b. Time Injury	of	28c. Injui	4 🗀 !	2	ne 5 Res		6 □Other (S y occurred	pecify)	
lal or Atter s efter dea li Director ed in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	200. Place	e of Injury - A ing, etc. (Spe	t home, farm, secify)	street, fact	ory, office		2		(Street an own, State		Rural	Route Number,
the Hospital or nin 24 hours effe the Funeral Dir npletely filled in I	Medical			Physician: To the aminer: On the b and man											
To the Within To the comp	Ž	29b. Signature and t	itle of certifier	MD				D o a					e signed (Mo	onth, D	ay, Year)
2 (2)		30. Name and addre	•			tem 23a) (Typ 1500 Fo	e, Print)				ilver	Spri	ng, MD		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** 2:00A M Watson 2006 Ward May Jesse 6 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Memoria If Under 24 Hrs. 6. Sex 8. Date of Birth Month, Day, Year Nov 2, 1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year **Funeral** Days 1 € M 2 □ F 220-10-0235 86 Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits than "naturel", or items 23s or 28e-f show the Medical Evanther must be notified at **Bedford** PA Bedford 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15522-5208 USA 3850 Evitts Creek Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW II 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify onfy highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Watson Drywall Co. 12 Owner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be (and Mental H Pages 1 and 2 should be finent of Health and Mental Norville Watson Nancy (Sachs) Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, **Bedford** PA 15522 3850 Evitts Creek Road Grace Watson wife to Health : 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State permit. Page: Department of Importent: If I injury or 5/18/2006 Sunset Memorial Park Cumberland MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Scarpelli Funeral Home, PA any ir 108 Virginia Avenue: Cumberland, MD 21502 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Aderocarcinomount months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: ff yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown ate hes been signed by page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yés 2 ☐ No 24a Was an 1 Yes 2 No certificate or Attending Physician: : Atter this certitics tuneral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident hours etter death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide tilled in within 24 hours e To the Funerel D 29a. Certifier 1 [Descritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D14865 May 16, 2006 ustras 1 Jana 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Memorial Ave, Suite 102 Comberland Robustiano J. Barrera Sr. M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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DI	1. Decedent's Name (First, Middle, Last,			<u></u>		2. Date of De Month		3. Time of Death
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Examiner Funeral Director	4a. Facility Name (If not institution, give Franklin Square 5. Social Security Number 0 6. Se. 215-03-5486	Hospital Ce	last birthday)	4b. City, Town, or POS-20 If Under 1 Year Months Days	r Location of Death da le If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th 9. B	ath Oure Country) ryland
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ertment of Health and Mental Hygiene. ortant: if Item 27 ie marked other then "natural", or Itema 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Application of the Applicati	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, hite, etc. White
ne then "natural", of the Medical Examination Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)		(Give	lent's Usual Occup kind of work done o DO NOT use retired Memaker	ation during most of work d)	king	16b. Kind of Busines	•
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Important: If any injury or ones	21. Signature of Funeral Service Licens		22	. Name and Addres	ss of Facility Jos onkling	seph N. St Bal	. Zannino Ltimore,M	Jr. FH
physician and subject the burial-transit and subject the burial-transit and subject to the burial-transit and subject to the burial transit an	Shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, a any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of): 5 D/as que ce of):	ia				Approximate Interval Between Onset and Death Lule K Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Composition Com
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actor, p	25. Was case referred to medical examiner?				26. Place of Deat	177	-121	13 2 140
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To the Funeral Director: completely filled in by the Medical Certificat	29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death	occurred at the timestigation, in my op-	ne, date and place, pinion, death occur	and due to the	cause(s) and manner a	as stated.
Mec	29b. Signature and title of certifier	· · · · · · · · · · · · · · · · · · ·		29c. License			29d. Date signed (Mor	
	30. Name and address of person who co	ompleted cause of death /hor	m 23a) /Tuna	Doo	56291	0	5-23- nore, Md 21	2006
2	Dr. Jason Birn	baum 9000) Frank	slin Squa	re Drive	6a 11in	pere, Md 21	237
State	31. Date filed (Month, Day, Year)		ature	C ARRES	/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Stata Registrar Amend Item \$8Per fh C856 6/12/10/6/care of Death Reg. No. Decedent's Name (First, Middle, Last)
Glascoe Austin Baker Sr. 2. Date of Death 3. Time of Death Year 8:52 A.M 2006 lay 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 5. Social Security Number 219 - 05 NA If Under 1 Year | If Under 24 Hrs. 6. Sex 1 △ M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 219-05-5903 Mary Land 83 Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Maryland NABaltimore Yes 2 □ No 10f. Zip Code 216 10e Street and Number 3012 Elgin Avenue 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
lifle. DO NOT use retired)
Educator 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Baker Maude Austin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3015 Elgin Ave Baltimore, Maryland 21216 19a. Informant's Name/Relationship (Type, Print) Glascoe A. Baker Jr. Son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5-30-2006 Baltimore, Maryland Arbutus Mem. Pk. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home PA of B. C 21. Signature Funeral Service Licensee 9200 Liberty Rd Randallstown, Md 21133 21. P n1. Enter k dise 1 e, or complete tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one carde on each line. Onset and Death Immediate Cause (Final Arterioscleratic Vasular disease or condition resulting in death) Due to (or as a consequence of): Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 🗌 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ≥ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pendina 2 Accident investigation 1 ☐ Yes 2 ☐ No

Examiner The law requires that the death certificate be executed 68760, o

C

MSCOR

Records, Division of Vital

as been signed by the attending physical should be detached for use as the has , page To the Hospitel or Attend within 24 hours after death To the Funeral Director: filled in by

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28s-f ahov the Medical Examinar must be notified at

Funeral Director

Be Completed by

death with the Maryland

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Hygiene.

Pages 1 and 2 should be f nent of Health and Mental P int: If Itam 27 is marked of

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Physician

/Medical

Examiner

Physician/Medical

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Completed

Be

Certification:

Medicai

Baltimore, Maryland 21215-0036

completely

State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

6 Could not be determined

120055849

29c. License number

May 22

281. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who come eted cause of death (Item 23a) (Type, Print)

900 Caton

Balknove Maryland

31. Date filed (Month, Day, Year) 2 4 2006

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29h Signature and title-of certifies

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** nes 440PM ON 2006 Mai /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b) City, Town, or Location of Death Examiner 5 0 WN D MOYR If Under 1 Year Year) 24 If Under 24 Hrs. 8. Date of Birth (Month, Day, 02 21 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2√□ F Yrs 82 Director 215-22-8701 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other then "naturel", or items 23s or 28s-f show other treumatic event, the Madical Expriner rules by multipled at 1 Yes 2 □ No Director NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21207 3004 Fairview Road death Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Š 3 ☐ Widowed 4 ☒ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry Aberdeen Proving al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Ground 7th grade Domestic Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Is marked of Annabell Williams John J. Wilson Sr. ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian Davis-Sister 3004 Fairview Road, Baltimore, Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. James UAME 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State St. permit. Page Department of Important: If eny injury or once. 4 □ Dopation 5 □ Other (Specify) Church Cemetery 5, 22. Name and Address of Facility 5/18/2006 Darlington, Md 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SDIra **Physician** MONI Der U /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 Ø No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy rmed? 2 No 212 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA the funeral dir 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 ZNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 62912 Hospitalist +Road Randall stown hristine Kajubi 5401 a 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registra 4 2006

			1 - For State of Maryla	and / Department of Health and N Certificate of Death	Mental Hygiene 006 16316
	Physici		1. Decedent's Name (First, Middle, Last)	BLACK	2. Date of Death Month Day Year 430 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Funeral Director	3	5. Social Security Number 6. Sex 7. Age (In yr 250-30-9659 1) M 2 F	rs. last birthday) 19 19 19 19 19 19 19 19 19 1	8. Date of Birth (Month, Day, Year) APRIL 12,1127 SOUTH CAROLINA
	and 2 should be filed within 72 hours after death with the Maryland astit and Mental Hygiene. n 27 ie marked other than "natural", or Itama 23e or 28e-f ehow na 27 ie marked other than "natural", or Itama 24e or 28e-f ehow int traumatic event, the Medical Examinatinatinatical at	To Be Completed by Funeral Director	10a. State 10b. County 10c. County 10c. County 10c. County 10c. County 10c. County 10c. County 10c. County 10c. County 10c. County 10c. County 10c. County 10c. County 10c. County 11c. Marital Status 12c. Was Decedent Ever in Armed Forces? 1	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) OPERATOR 18. Mother's Name SUSI 19b. Mailing Address (Street and Number or Rura 19 N. BERNICE A	10g. Citizen of What Country? 9 14. Race - American Indian, Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry CONTINENTAL CANCO 16e (First, Middle, Maiden Sumame) 16 MAE GILYARD 17al Route Number, City or Town, State, Zip Code) VE, BALTIHORE MD. 21229
Baltimore,	permit. Pages 1 and Department of Healt Important: If Item 2 eny injury or other 2000s.		1. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Licensee 23a. Part 1. Enter the disease, or complications that caused the de	D. Place of Disposition (Name of cometery, crematory or other place) OODLAWN CEMETER 05 - 22. Name and Address of F. cility 214 Toseph H. Brown, Jr.	Date / 20c. Location Thy or Town, State 24-06 MODLAWN MD. 10 N. Fulton Avenue 2/217 Funeral Home Baltimore MD.
	death certificate be executed By Aman Caraman and Caraman and Caraman and Caraman and Caraman are as the burial-transit	Ical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consider of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the	equence of):	Onset and Death
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	atcian: The law requires thet the scentificate has been signed by th inector, page 2 should be detached.	Completed			24a. Was an autopsy performed? 1
0	ng Phy fter this meral d	atlon: To Be	27. Manner of Death 1 ♥ Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Ho	th (Check only one) ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
Division	al or Atte s after de il Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spe		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the fu	Medical (cnowledge, death occurred at the time, date and place, ination and/or investigation, in my opinion, death occurr 29c. License number	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
)	+ ≥ - 8		Rula Windows a	30 NO E L	5/23/06
	6		30. Name and address of person who completed cause of death (It	TOO WARHINGTON PRI	() BAG-more MIS 71223
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32! Registrar's Sig	Inature	

_			1 - For State Registrar		/larylan			of Health and of Death		Reg. No.	06	16317
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	Funeral Director		5. Social Security Number 219–16–9754 Usual Residence of Decedent		Age (In yrs.	, ,	If Under Y Months D	ear If Under 24 Hrs ays Hours Min.	(Month, Da		9. Birthp	place (State or Foreign ntry) yland
	filed within 72 hours after death with the Maryland Hygiene. Hydiene 13e or 28e-f ethow inther than "naturel", or iteme 23e or 28e-f ethow int, the Musical Exercities and interest the notified at	Director	Maryland Anne A 10e. Street and Number 859 Woods Road	rundel	10c. Cit	y, Town or Loca Pasaden	a 10f. Zip Co	_{de} 1122		10g. Citizen o		10d. Inside City Limits 1 ☐ Yes 2 M No ntry?
036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Depertment if item 27 is marked other than "neturel", or items 28s or 28s-f show any injury or other traumatic event, the Musical Exercities must be mullified as page.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force: 1 Yes 2 If Yes, Give Year or Dates	s?] No	1		of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No to Rican, etc.)		ace - Americack, White,	etc.
Baltimore. Marvland 21215-0036	led within 72 ho lygiene. her than "natu nt, the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		ır 5+)	1	it's Usual O od of work d NOT use re ilern	one during most of wo etired) aker			1 193	,
farvland	2 should be fill and Mental H is marked ott reumatic even	To Be	17. Father's Name (First, Middle, Last) Charles L. 19a. Informant's Name/Relationship (7)			1		Cather reet and Number or Ru	ural Route Numbe	Kennedy or, City or Tow	n, State, Zip	Code)
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~/r/ 8760.	m	dical Examiner	Instruction of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the co	aDue to (or a b	tast	unterpresentation of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	PICT PUCT FER	gspte	Cane t LMONH Iseast	20	EASE	Onset and Death 2 weeks 104 Rass Tycars
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ohn ecords. P	w requires that been signed b should be deta	b	Part II. Other significant conditions of	ontributing to death	but not resi	utting in the unde	erlying caus	e given in Part I.	23e. Did to		_	he cause of death? pably 4 □Unknown
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oj.	Hospital or 4 hours afte Funeral Dir iely filled in t	Medical Certi	29a. Certifier 1 Certifying Ph	building, ysician: To the be	etc. (Specify	v) wledge, death o	ocurred at the	ne time, date and place ny opinion, death occu	City or Tow	m, State)	nanner as st	tated
9	To the within 2 To the complet	Me	29b. Signature and title of certifier	pompleted cause of	bal	Jan 2000	0	2_00 9 Y		29d. Date sign	ed (Month, I	Dey, Year)
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 2 4 201	4 mp 1	death (Item	Mad	Sa	fark Or	ive, 61	len Bu	rnie	Md, 2106/

Amend PII, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Day C Month 02a M **Physician** 0006 /Medical 4a. Facility Name (If not institution, give street and number) c. County of Death 4b Cty, Town, or Location of Death Examiner Baltimore n/a Mercy Medical Center tf Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Phillipines 5. Social Security Number 6. Sex Date of Birth (Month, Day, 9/6/2 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 X F 80 Yrs 219-19-5089 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County ir than "natural", or items 23a or 28e-f show the Medical Examinar must be notified at 1° ¥ Yes 2 □ No Director Baltimore Md n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 1114 Steeleton Avenue Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Inportent: If item 27 is marked other than "natural", or iten sny injury or other traumatic avant, tra Mudical Evantical once. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 X Yes 2 □ No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Asian-Spanish Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Dentistry Dentist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Natalio Lazaro Agustina Del Rosario 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin & Merlinda Bogtong 1114 Steeleton Ave. Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1. Burial 2 ☐ Cremation 3 ☐ Removal from State 5/27/06 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Baltimore, Md. 21. Signature of Funeral Service License Kararan Home P.A. Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician nouman /Medical due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-transit Due to Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of detivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months
1 Yes 2 DNo Month Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Cerebrovascular disease, arterial fibrillation, deep venous 3 Probably 4 Dishknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? thrombosis, gastrointestinal bleed 24a. Was an autopsy performed? this certificate 2 No 2 No 1 Tes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient funeral dir 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No within 24 hours after death.
To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the th 29b. Signature and title of certifier 29c. License number Date signed (Month, Day, Year) ), M.: 00000501 completed cause of death (Item 23a) (Type, Print)

Bullimon, MD 21244

32. Registrar's Signature 0001 31. Date filed (Month, Bay, Year) State profes MAY 2 4 2006 Registrar

£06-03344-Kora Blunt

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	or waryland	•	icate of D	eath	incar i rys		g. No.	200	5 1531
Physici		1. Decedent's Name (First, Middle, L	ast)					. Date of Deatl Month	Day	Year	3. Time of Death
ledical Exami	iner	Kora S. Blunt  4a. Facility Name (if not institution, g	ive street and number)		I 4b /	City, Town, or Location		May 17, 20	006	County of Death	2047 hrs
<u>.</u>		University Hospital Shoo				altimore City	n or Death		40. 0	Jounty of Death	
Funeral				e (In yrs. last b			der 24Hrs.	8. Date of Birt	h(MM/DI	D/YYYY) 9. Birt	hplace (State or
Director		219-37-9097	M 2XF	13	— —	Months Days Ho				Foreig	
		Usual Residence of Decedent		13	110.			02-06-19	993		// MD
v any		10a. State 10b. County		10c. City, Tov	vn or Location						10d. Inside City Limits
Aaryland 28a-f show any 1 at once,	or	MD N	Α			Baltimore					1 X Yes 2 No
Mary 28a-	Director	10e. Street and Number			10	f. Zip Code		10	g. Citize	n of What Coun	try?
th the Maryland 23a or 28a-f sho notified at once		2306 Winchester St.	^			21216				USA	
ath wi tems	neral	11. Marital Status  1 X Never Married 2 Married	12. Was Decedent Armed Forces?			ecedent of Hispanic C specify Cuban, Mexic			14	<ol> <li>Race - Americ White, etc.</li> </ol>	ean Indian, Black,
ter de ", or i	F.	3 Widowed 4 Divorc	ed If Yes, Give Year	<b>X</b> No	1 Ye	s 2 X No speci	fv:		St	pecify:	Black
ours af I <b>tural</b> amin	d by	15. Decedent's Education (Specify	only highest grade com	pleted) 16	a. Decedent's U	Isual Occupation (Giv	e kind of wor		نطب	nd of Business/Ir	
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MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygien Arman arms or items 23a or 28a-fishen mastic event, the Medical Examiner must be notified at once mustic event, the Medical Examiner must be notified at once	ပိ	17. Father's Name (First, Middle, La Sylvester Conn	st)					irst, Middle, M	laiden Su	urname)	
212 uld be Ments marks even	0 8	19a. Informant's Name/Relationship	(Type, Print )	- 1	19b. Mailing Ad	dress (Street and N	elley Dumber or Run		ber. City	or Town, State	Zip Code)
MD d 2 sho lth and n 27 is		Sylvester Conn/ F	ather	1		antico Avenu			-		<i>,</i>
		2Ca. Method of Disposition				(Name of cemetery,		Date		cation - City or	Town, State
MOI Pages ent of int: I		1 X Burial 2 Cremation 3		ile I	emorial]	•	05-25-	-06	Rand	dal1stown	. MD
Baltimore, permit. Pages I as Department of He Important: If ite injury or other tr	13	21 Signature of Funeral Service Lic	<u> </u>	1-101-1-		and Address of Faci	-				,
	9. 9	C.,00:	mes			Funeral Hom			_		, MD 21217
Physician /Medical		23a. Part I. Enter the disease, or cor failure. List only one cause on		the death. Do	not enter the m	ode of dying, such as	cardiac or re	espiratory arre	st, shock	k, or heart	Approximate Interval Between Onset and
Examiner	3 6	Immediate Cause (Final disease or condition resulting in death)	Multiple Injuries	6							Death
		-	Due to (or as a conse	equence or).							
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760, cate be execut physician and he burial - tran	Medical	UNPENDED	AMENDED								
760, Teate be g physici the buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	ne of pregnanc	· —	. —				Date of delivery	
Box 687; death certificate attending	siclan	past 12 months?	1 Live birth 4 Pregnant at	time of death	2 Fetal d	eath 3Ecto (Specify)	oic pregnanc	у	M	onth Da	ay Year
Boy e death the attr	Physi	1 Yes 2 No 9 V Unknow	vn 9 Unknown		o Other	(Opecny)					
b.O. B that the d ned by the detached	by PI	Part II. Other significant condition	contributing to death	but not result	ting in the unde	rlying cause given in	Part I.				ne cause of death?
S, P.C uires that n signed I d be deta										No 3 Proba	ably 4 Unknown
cords law requir has been a	plet							24a. Was a autops	у	prior to co	opsy findings available impletion of cause of
Rec The la	Completed							perform 1 <b>Y</b> Yes 2		death? 1 ✓ Yes	2 No
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ision Attender death	icati	2 Accident Investig	28e Place of In	urv - At home	farm street fa	ctory, office building,	-	Rf Location (St	reet and	Number or Pur	al Route Number, City
Div pital or ours afte reral Div	Certification:	3 Suicide 6 Could no determine	ot be		, 14111, 011001, 14	otory, omeo banang,	2210	or Town, Sta	ate)	Street, Baltin	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical		er:On the basis of exar and manner stated.								
F % F 8	Me	29b. Signature and title of certifier			<del></del>	29c. License numbe	er		29d. Dat	te signed (Mont	h, Day, Year)
		my hi, h	m)>			O.C.M.E.			May 1	8, 2006	
3		30. Name and address of person wh		`	•	altime - to a	201				
		Ling Li, MD Assistant  31. Date filed (Month, Day, Year)	Medical Examiner  32 Segistrar		nn Street, E	Baltimore, MD 21	∠U1				
S Regis	tate trar		006 Magazi	Olynature	Annie	9					
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06-03280 Larry J. Bailey

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		- For State		Certificat	e of	Death	<u> </u>			eg. No.	Eno (		b !	536
Physicia ledical Examir	n/	Decedent's Name (First, Middle, Lass     Larry Bai							Date of Dea Month May 15, 2	Day	Year		3 Time of E 2200 h	
		4a. Facility Name (if not institution, give	•		4	b. City, Town, or	Location of				County of	Death		
		Bon Secours Hospital	[7 A - //	n yrs. last birtho		Baltimore  If Under 1 Yea	. It lade	- 0 41 Jan - To	Date of Bi	eth / 8 4 4 / D /	20000	O Dieth	nlago (Stat	0.05
Funeral Director	1	5. Social Security Number 6. Sec. 212–48–1324	7. Age (III) M 2 F 5	Min	3. Date of Bi			Foreign Cou	1	MD				
	ŀ	Usual Residence of Decedent	JC		Yrs.			1	02 20 .					
any	ı	10a. State 10b. County	10	c. City, Town or									10d. Inside	
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urs aft tural"	희	15. Decedent's Education (Specify or	or Dates:		cedent	's Usual Occupa	tion (Give k				nd of Bus			
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Tried by O	-	Gloria Bates/ Sister		- 1	1020	N. Payson	n Stree	et Balt	timore,	MD 212	217			1.0
	Ì	20a. Method of Disposition		20b. Place of cremator		tion (Name of ce	metery,	D	ate	20c. Lo	cation - (	City or T	own, State	
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8760, tificate be ng physic as the bur	M/m	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth		Fet	al death 3	Ectopic	: pregnancy	у		Date of of football		эу	Year
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O. Box 687 at the death certifi d by the attending	Physiciar	Part II. Other significant conditions	9 OHKHOWH	ut not resulting	in the u	nderlying cause	given in Pa	rt I.	23e. Did	obacco us	se contrib	oute to the	ne cause of	death?
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Division of Vital Records, spiral and requir borns alter death.  Ineral Director: After this certificate has been sy filled in by the funeral director, page 2 should the filled in by the funeral director, page 2 should the funeral director.	Certification:	3 Suicide 6 Could not determine		y - At home, far	m, stree	t, factory, office	building, et	c. 28	or Town,		d Numbe	r or Rur	al Route Nu	ımber, City
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Divi To the Hospital or within 24 hours afte To the Funeral Dir	Medical	one) 2 Medical Examine	r: On the basis of examinand manner stated.	nation and/or in	vestigat	ion, in my opinio	n, death oc	curred at th	ne time, date	and plac	e, and du	e to the	cause(s)	
<u> </u>	Me	29b. Signature and title of certifier	one marinor stated.			29c. Licen:							th, Day, Yea	ir)
113		( and 4	allan	_		O.C.	.M.E.			May	16, 200	06		
Bur		30. Name and address of person who Carol Allan, MD Assista	completed cause of dea		enn G	Street, Baltim	nore MD	21201						
1 1	tate		32. Registrar's		5/111	0	.5.5, WID							
Regis		BR BS / O /	2001	ers M	A	Sell J								

WILTON

ARNES,

17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  18. Mother's Name (First, Middle, Maiden Sumame)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  19. Informant's Name/Reliationship (Type, Print)  10. Informant's Name/Reliationship (Type, Print)  10. Informant's Name/Reliationship (Type, Print)  10. Informant's Name/Reliationship (Type, Print)  10. Informant's Name/Reliationship (Type, Print)  10. Informant's Name/Reliationship (Type, Print)  10. Informant's Name/Reliationship (Type, Print)  10. Informant's Name/Reliationship (Type, Print)  10. Informant's Name/Reliationship (Type, Print)  10. Informant's Name/Reliationship (Type, Print)  10. Informant's Name/Reliationship (Type, Print)  10. Informant's Name/Reliationship (Type, Print)  10. Informant's Name/Reliationship (Type, Print)  10. Informant's Name/Reliationship (Type, Print)  10. I				1 - For State Registrar	State of Maryla		artment of H rtificate of L		nd Mer	ntal Hygie	71111	16322
DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECTOR  DIRECT				BLANCHE					r	Mary 18	200€	9.50 p. M
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Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit   Disasted Colf Junit		Funeral		5. Social Security Number 6. Sex	7. Age (In yr.	s. last birthday)	If Under 1 Year	If Under 24	4 Hrs. 8.			
10.5 State   10.5 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 State   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10.6 Coarry   10				X12.30.04.14	M 200 F 97	Yrs.	MOII(IIS Days	Hours	0	1. 12. 1909	ar,	sc.
MIKE WOOD BERRY   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   ST		yland			10c. (	City, Town or Lo	ocation					10d. Inside City Limits
MIKE WOOD BERRY   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   ST		B Mar	ctor	MD NA	BA	LTIMORE	5					1 ⊠ Yes 2 □ No
MIKE WOOD BERRY   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   STREL   ST	:	with the	Dire		7					10g.	_	country?
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FEMALE:   236. If yes, outcome of pregnancy   1   Live bitth   2   Fetal death   3   Ectopic pregnancy   1   Live bitth   2   Fetal death   4   Pregnant at time of death   5   Other (specify)   236. Date of deivery   Month   Day   Year   241. Was an autopsey   1   Yes   2   No   3   Probably   4   Unknown   244. Was an autopsey   25. Was case referred to medical assaminary   1   Yes   2   No   No   No   No   No   No   No	. 260	ysicial		d.								
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2006 Year **Physician** 3:15 P M May 20 Laurence McKenzie Bearse /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford **Fallston** 2209 Furnace Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 2, 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1937 68 031-26-2621 Yrs. Massachusetts Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **wode** 7 is marked other then "naturel", or iteme 23s or 28e-f ehor treumatic event, the Modical Examinar must be nutified at 1 Yes 2 No Funeral Directo MD Harford Fallston 6 4 1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2209 Furnace Road 21047 USA 12. Was Decedent Ever in U.S.
Arned Forces?
1M√Ves 2 □ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 Specify Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Joint Military 1.2 should be filed within 7 h and Mental Hygiene.
7 Is marked other then "! Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attache' School Associate Dean 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jean McKenzie Laurence W. Bearse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 wife 2209 Furnace Road; Fallston, MD 21047 Linda Graham other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Commation 3 Removal from State 0 Depertment Important: If eny injury or once. 5/23/06 Hilltop Service Corp. Towson, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Ferrice Libers 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YMPHOMA **Physician** YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner 14 use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): /sicien Box 68760 Be Completed by Physician/Medical certificate has been signed by the attending rector, page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an autopsy performed 1 ☐ Yes 2 of Vital 25. Was case referred to medical director 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Other: 4 Nursing Home 5 Asidence 6 Other (Specify) After the funeral of 27. Manner of Death Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification; 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Midical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29c. License number 29b. Signature and time 29d. Date signed (Month, Day, Year) 22/06 ated cause of death (Item 23a) (Type, Print) Print) O SUITE 200 LUTHER VILLE, MD 21093 30. Name and address ERIC J. SEIFTER 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar 1

06-03428 Please Type or Print in Black Indelible Ink William Barnes State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 20, 2006 Medical Examiner 1608 hrs William Barnes Τ. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Saint Joseph Medical Center Towson **Baltimore County** 9. Birthplace (State of 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreignPennsylvania Months Days Hours Min Director July 16,1960 1 X M 2 F 45 219-86-6243 Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f show Maryland Lutherville Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Martingale Road 21093 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 Married Yes 4 Divorced If Yes. Give Year 1 Yes 2 X No specify: 3 Widowed Specify. White Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner þ Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Electronic Technician Medical 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Denyse Culver Thomas С. Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mother 108 Martingale Road Lutherville, Maryland 21093 M. Denyse Barnes

**Physician** kaminer

and Division of Vital Records, P.O. Box 68760,

	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State	crematory or other	ion (Name of cemetery, er place)	Dat	te	20c. Location - City or	Town, State	
	Donation of Other Specify: Hilltop Service Corp. 5-24-2006 Towson, Ma							
	21. Signature pr/Funeral Service Licensee	22. Na	me and Address of Facil			n Funeral H	lome Inc	
	Haw Witnessen		50 York Road	d Tow	≀son, N	Maryland 21	204	
	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	death. Do not enter the	e mode of dying, such as	cardiac or res	piratory arres	st, shock, or heart	Approximate Interval Between Onset and	
	Immediate Cause (Final disease a. Atherosclerot	cic Cardiovas	scular Disease				Death	
	or condition resulting in death)  Due to (or as a consequence)	ence of):						
	Sequentially list conditions, b.							
ē	if any, leading to immediate Due to (or as a consequent	ence of):						
ni Li	cause Enter Underlying Cause (Disease or injury that initiated						j .	
Examiner	events resulting in death) Last Due to (or as a consequence	ence of):						
	d.							
Be Completed by Physician/Medical	X unpended □ amended item#2	23a,27,perME,	3856,6/8/06 TT					
Me	IF FEMALE: 23c. If yes, outcome of	of pregnancy				23d. Date of delivery	-	
an/	23b, Was decedent pregnant in the past 12 months?	2	al death 3 Ector	oic pregnancy		Month D	ay Year	
sici	1 Yes 2 No 9 Unknown 2 Unknown	e of death 5 Oth	er (Specify)					
hş								
V P	Part II. Other significant conditions contributing to death but	t not resulting in the ur	iderlying cause given in F	Part I.	23e. Did tob	acco use contribute to	the cause of death?	
d b					1 Yes	2 No 3 Prob	ably 4 🗸 Unknown	
ete					24a. Was ar		topsy findings available	
ğ					autops) perform		ompletion of cause of	
õ					1 🗸 Yes 2	No 1 ✓ Ye	s 2 No	
e C	25. Was case referred to medical		26.Place of Deatl	h (Check only o	one)			
	examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient	2 🗸 ER/Outpatient	3 DOA Other	Nursing Ho	me 5 R	esidence 6 Other		
[:	27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time of In	jury 28c. Injury at Wo	rk? 28d.	Describe ho	w injury occurred		
ē	1 X Natural 5 Pending (Month, Day, Year)	ļ	1 Yes 2	No				
ica	2 Accident Investigation 28e, Place of Injury	- At home, farm, stree	, factory, office building,	etc. 28f.	Location (St	reet and Number or Ru	ral Route Number, City	
Certification: To	Suicide Could not be determined (Specify)		,,		or Town, Sta		, 500,	
	700 Cortifies			4				
Medical	Certifying Physician: To the best of my kr   (Check only   1   Certifying Physician: To the best of my kr   one)   2   Medical Examiner: On the basis of examiner							
edi	and manner stated.	ation and/or investigati						
>	29b. Signature and title of certifier		29c. License numbe	er	1	29d Date signed (Mor	th Day Year)	

29c. License number O.C.M.E.

29d Date signed (Month, Day, Year)

May 22, 2006

State

within 2 To the I

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ling Li, MD

mo

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Romaine Brown  Annapolis Nursing & Rehab  Annapolis Nursing & Rehab  Annapolis Nursing & Rehab  Annapolis Nursing & Rehab  Annapolis Nursing & Rehab  In Again y Name (if not situltion, give street and number)  Annapolis Nursing & Rehab  Annapolis Nursing & Rehab  In Annapolis Nursing & Rehab  In Annapolis Nursing & Rehab  In Annapolis Nursing & Rehab  In Annapolis Nursing & Rehab  In Annapolis Nursing & Rehab  In Annapolis Nursing & Rehab  In Maryland Anna Arunde  In Annapolis Nursing & Rehab  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the street and number)  In Annapolis Nursing (if the	ate or Foreign a d  ie City Limits  Yes 2 □ No
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Security Name (In or Institution, pive street and number)   Annapolis Nursing & Rehab   Annapolis Nursing & Rehab   Annapolis Nursing & Rehab   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Annapolis   Anna	ate or Foreign a d  ie City Limits  Yes 2 □ No
S. Social Security Number  215-24-3804  10 M 3/2 F  7. Age (In yrs. last birthday) 78 Yrs.  Months Cays Hours Min. Marth 11 Yay Yar/28 8  10 Loss Headence of Decedent 10a. State 10c. County Maryland Anne Arundel Annapolis  Maryland Anne Arundel Annapolis  10c. City, Town or Location  Annapolis  10d. Isia Decedent Mispanic Crigin? (Specify Yes or No-Black, White, etc. Specify) 11 Martal Status  11 Martal Status  11 Martal Status  11 Martal Status  12 Was Decedent of Mispanic Crigin? (Specify Yes or No-Black, White, etc. Specify Cuban. Maxican. Puerto Rican, etc.)  13 Was Decedent of Mispanic Crigin? (Specify Yes or No-Black, White, etc. Specify Cuban. Maxican. Puerto Rican, etc.)  13 Was Decedent of Mispanic Crigin? (Specify Yes or No-Black, White, etc.)  14 Was Decedent of Mispanic Crigin? (Specify Yes or No-Black, White, etc.)  15 Decedent's Education  15 Decedent's Education  15 Decedent's Education  15 Decedent's Education  15 Decedent's Education  15 Decedent's Education  16 Demensary/Secondary (0-12)  17 Father's Name (First, Middle, Last)  18 Mother's Name (First, Middle, Maiden Sumame)  19 Desemble of Decedent of Mispanic Crigin? (Specify Yes or No-Black, White, etc.)  19 Desemble of Decedent's Education  19 Desemble of Decedent's Education  10 Desemble of Decedent's Education  10 Desemble of Decedent's Education  11 Decedent's Usual Occupation  12 Decedent's Usual Occupation  13 Maximal Rationary Decedent's Usual Occupation  14 Desemble of Decedent's Education  15 Decedent's Usual Occupation  15 Decedent's Usual Occupation  15 Decedent's Usual Occupation  16 Decedent's Usual Occupation  16 Decedent's Usual Occupation  17 Father's Name (First, Middle, Maiden Sumame)  18 Monther's Name (First, Middle, Maiden Sumame)  19 Desemble of Decedent of Decedent Sumame)  19 Desemble of Decedent's Usual Occupation  10 Decedent's Usual Occupation  10 Decedent's Usual Occupation  10 Decedent's Usual Occupation  10 Decedent's Usual Occupation  10 Decedent's Usual Occupation  10 Decedent's Usual Occupation  10 Decedent'	ate or Foreign a d  ie City Limits  Yes 2 □ No
Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Direct	e City Limits Yes 2 □ No
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insight 10b. Street and Number 831 Bestgate Rd. 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 12. Marned Forces? 11. Marital Status 12. Marned Forces? 11. Marital Status 12. Marned Forces? 12. Marned Forces? 12. Marned Forces? 12. Marned Forces? 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 13. Was Decedent's Usual Occupation (Specify only highest grade completed) 11. Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Status 12. Marned Marital Statu	e City Limits Yes 2 □ No
Avon Jones (Son)    Sal Bestgate Rd. Annapolis, Md. 21401	Yes 2 □ No
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Avon Jones (Son)    Sal Bestgate Rd. Annapolis, Md. 21401	
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Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Exa	
Physician //Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
Physician //Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	•
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Physician /Medical Examiner  Sequentially list conditions, if any, leading to immediate in any, leading to immediate in a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	mate Between
Medical Examiner  Sequentially list conditions, if any, leading to immediate any, leading to immediate any, leading to immediate.  Due to (or as a consequence of):  Due to (or as a consequence of):	and Death
o if any, leading to immediate Due to (or as a consequence of):	,
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4 S S a D I I E FEMALE:	
23c. If yes, outcome of pregnancy  23d. Date of delivery	
Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   Second   S	Year
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Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause given in Part I.	
1 Pres 2 No 3 Probably 4	
24a. Was an autopsy find autopsy	igs available of cause of
24a. Was an autopsy find prior to completion death?  1 Yes 2 Ho o o o o o o o o o o o o o o o o o	
25. Was case referred to medical examiner?	
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
28d. Describe how injury occurred    Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution   Constitution	
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28d. Describe how injury occurred  1	romber,
To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
25. Was case referred to medical examiner?  1	30(S)
29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Ye.	
1 July Devent 039936 2129/200	0
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Brint) Dr., we Cherke. Mi) 2/6/9  31. Date filed (Month Day Year)  32. Benistrat's Signature.	
State Registrar MAY 2 4 2006 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 530 PM 22 2006 ammor a a /Medical 4c. County of Death Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ba OWN IMOVE thwes a 0 9. Birthplace (State or Foreign Country)
MARVLAND If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 18, 1928 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days 220-20-4892 1 ☐ M 2 🔀 F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County with the Maryland 10a State r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 220 USA. TCELL Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify BLACK Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Flementary/Secondary (0-12) College (1-4or 5+) other than BALTO CITY PUBLIC SCHEEKS 7 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny injury or other traumatic event Stock. Be KUDOLPH ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) MONTICELLO KD BALTO. MD. 21216 EDMOND LONESOME 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 30-06 BUTUS CEMETERY 4 ☐Donation 5 ☐ Other (Specify) FUNERAL 21. Signature of Funeral Service Licensee BALTO. MD. 21 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 45 a erebrovascu **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed physicien and Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?

1 Yes 2 No
9 Unknown ò 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed **2**₾ No 2/ No 1 Yes 1 🔲 Yes bitcute Six director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) unit 1 Yes 2 No 2 ER/Outpatient 3 DOA this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Medical Certification: 1 Natural
2 Accident Division 5 Pending within 24 hours efter death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as section.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2006 May Hospitalist une Jajum completed cause of death (It m 23a) (Type, Print) Name and address of person wito.

DHMH 17 Rev 1/2001

State Registrar hristine

31. Date filed (Month, Day, Year)

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ORIGINAL

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32. Registrar's Signature

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			For State Registrar	State of Marylan	•	rtment of F			giene 2006	16327
	Physici	an	Decedent's Name (First, Middle, Last)	LBERT-LEHMAN				2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give to BaHIMORE WASh	street and number)	al Ctr.	Gren,	Burne		4c. County of Death	huses
b	Funeral Director		212-07-9770	7. Age (In yrs. 94	(ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth May 7,	1912 Mar	nplace (State or Foreign y Land
	sryland	_	Usual Residence of Decedent  10a. State  10b. County		y, Town or Lo			<u> </u>		10d. Inside City Limits 1 ☐ Yes 2 📝 No
	the Ma	recto	Maryland Anne Ar	rundel	Arnol	10f. Zip Code		1	10g. Citizen of What Co	
	23a or	a Di	915 Juliet Lane			21012	2		U.S.A.	
036	hours after death with the Maryland ural, or Items 23e or 28e-1 show at Exerciner must be notified at	by Funeral Director	11. Marital Slatus  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	l:	Vas Decedent of H f Yes, specify Cuba	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White WI Specify:	
Maryland 21215-0036	within 72 ane. than "nat	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	leni's Usual Occup kind of work done DO NOT use retired Stodian	ation during most of work d)	king	Board of Business/I	Education
land 2	ould be filed Mental Hygid arked other atic event, ii	To Be C	17. Father's Name (First, Middle, Last) Frank I	arkins					Maiden Sumame) 2656	
Mary	S E E		19a. Informant's Name/Relationship (Ty Constance Sheffie	(grand ,					r, City or Town, State, Z lena, Maryla	
		8	20a. Method of Disposition  1 Burial 2 Cremation 3 🗆	20b. F	Place of Disposemetery, crem	sition (Name of natory or other place	ce)	Date	20c. Location - City or	Town, State
Baltimore,	it. Pa rtmen rtant: njury		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	G1e	1	n Mem. Pa		4-06	Glen Burnie	e, Maryland
Ba	Depa impo eny is		Jun Son	anul )					ome P.A. na, Maryland	
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final	ications that caused the death						Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq	uence of):	moure i	150 79 Cen	enux c	eny Deserge	e yayn.
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):					
A	cate be executed bhysicien and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	cate be ohysicie the buri	dicai	C.	1.						
.O. Box 6	nt the death certificate be executed by the attending physicien and tached for use as the burtal-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)	1		23d. Date of deli	very Day Year
Ω.	es that igned by be deta	٥	Part II. Other significant conditions con	ntributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.		bacco use contribute to	
cord	The law requires that ste has been signed b sage 2 should be deta	leted	Box & bi	Lan O Za	ust l	Lilenc	upple_	24a. Was a	es 2 No 3 Pro an 24b. Were au	bbably 4 □Unknown topsy findings available
Vital Records,		Completed	- yes servers	junia an	10	out we	9	autops perfor 1  Yes	sv prior to c	ompletion of eause of
Vita	Physician: T this certificet ral director, pa	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	ER/Outpatien	t 3□ DOA Oth	or	th Check on or	nel ence 6 □Other (Spec	ofu)
ion of	nding Phy th. :: After thi e funeral o	ation: T	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Dale of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at		ow injury occurred	"9)
Division	Hospital or Attending 24 hours after death. Funeral Director: After itely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Al ho building, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (S. City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical (	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my knoner: On the basis of examina and manner stated.	wiedge, death tion and/or inv	occurred at the tire restigation, in my o	ne, date and place, pinion, death occur	, and due to the c rred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To th Withii To th	W	29b. Signature and title of certifier	0	, ,	29c. Licens	e number	2	9d. Date signed (Month	
7	2		30. Name and address of person who co	empleted cause of death (Item	123a) (Type,	Print) DA	46 K	Care de	red 20	77 28K
	)		31. Date filed (Month, Day, Year)	32 Aegistrar's Signa	we-	Glew	Person E	Red	20061	
	Sta Registi		MAY 2 4 200	E L	J. Jan	ales de				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Barry Month D. 7:*55* A M Carroll MAY 110 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE WASHINGTON MEDICAL CENTER BURNIE Il Under 24 Hrs. CLEN ARUNDEL ANNE If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days 1**⊠** M 2□ F Min. Hours 214-62-8763 48 Yrs. Director Jan 1958 Maryland 20 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "naturel", or items 23a or 28a-f ehow The Medical Examiner must be notified at Severn Maryland Anne Arundel 1 ☐ Yes 2X No Direct 10e. Street and Number 10f Zin Code 10g. Citizen of Whal Country? 918 S. Wieker Rd. 21144 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 M Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes **Ж**No Specify: Black þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Heelth and Mental Hygiene. Important: if fam 27 is marked other than "nea any injury or other traumatic even." B. F. Elementary/Secondary (0-12) College (1-4or 5+) Foreman 12th Carroll Contractor's 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Berkley Carroll Anne Hester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Harris (Mother) 918 S. Wieker Rd. Severn, Md. 21144 20b. Place of Disposition (Name of cometery, crematory or other place)
Maryland Veteran 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-24-06 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Wm. Reese of Earlistons Mortuary, P.A. , Beese MO0483 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Belweer Immediate Cause (Final disease or condition resulting in death) and Death encephalonath Physician days /Medical Due to (or as a consequence of): Examiner DIVATOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 npatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Certification; To 27. Manner of Death 28a. Dale of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be Place of Injury - Al home, farm, street, factory, office building, elc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/2 Certifying Physicien: To the best of my knowledge death accurred at the time, this and place and dust the name (c) and interior at stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOOAZ463 May 16, cause of death (Item 23a) (Type. Print) Dr. Glen Burnie, MD 21061 STUArt acabs 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2006 Registrar

DHMH 17 Rev 1/2001

ARROLL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day9 **Physician** Manth 2006 12:00p M Alban Ν. Dupuis /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore St. Martins Nursing Home Catonsville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Jan 6, 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1**X** M 2□ F 89 026-05-5486 Massachusetts Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 ahow traumatic ayant, the Medical Examiner ount be notified at Director Baltimore Page 1 Catonsville 1 ☐ Yes 2 X No Md. 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? or itema 23a or USA 601 Maiden Choice Lane 21228 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ģ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerical Water Company Pages 1 and 2 should be filed vent of Health and Mental Hygie int: if item 27 is marked other? 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rose Delima Adjutor Dupuis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 ia
any injury or other trau Mr. Ronald Langis/ Nephew 1375 Wilson Point Rd. Baltimore, Md. 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Notre Dame Cemetery 5-26-06 Fall River, MA. 4 ☐ Donation 5 ♠Other (Specify) ²²Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia **Physician** disease or condition resulting in death) /Medical Keart-failure Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit attending physicien and Physician/Medical use as the IF FEMALE. 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 🗌 Unknown Part If. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After Certification: 1 Natural To the Hospitel or Attending 5 Pending investigation death. 1 Yes 2 No 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c ± icense number 29b. Signature and title of certifier Urkasan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3455 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2008 Registrar

DHMH 17 Rev 1/2001

Box 68760.

			1 - For State Registrar	State of Marylar	-	artment of H			ene) () () (6	16330
	0		Decedent's Name (First, Middle, La	st)		timodito or		2. Date of Death	j. 140.	3. Time of Death
	Physici		William Do	nald Disharo	on			Month	$21^{\text{Day}}, 200^{\text{Year}}$	12:17 a.
	/Medic Examin		4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, o	or Location of Deat		4c. County of Death	
	Exami	Ψ.	Gilchrist Cente	er		T	owson		Baltimo	re Co.
	Funeral		Social Security Number     6. 9		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	0 B:45	place (State or Foreign
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	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	danyia i sho	ō		ore Co.						1 ☐ Yes 2 No
	28a-1	Director	10e. Street and Number	ore co.	Par	kville 10f. Zip Code		100	g. Citizen of What Cou	ntn/?
	with Se or		2502 Creighton	Avenue		100	234	'	United Sta	•
	ns 2%	Funeral	11. Marital Status	12. Was Decedent Ever in U	I.S. 13. 1		dispanic Origin? (S an, Mexican, Puen	pecify Yes or No-	14. Race - Ameri	
٥	or Iter		1 Never Married 2 Married	Armed Forces? 1 □AYes 2 □ No				o Rican, etc.)	Black, White,	
3	rel', c	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: Kor	ean	I□Yes a\□No	Specify:		Specify:Whit	е
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ither then "naturel", or Items 23e or 28e-f show ant, the Modical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr		(Give	lent's Usual Occup kind of work done	during most of wor	king 16	6b. Kind of Business/In	dustry
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	iled v lygie iher t	ပိ	12 17. Father's Name (First, Middle, Last	2 1/2 yrs.		Surgical	Supplie:	ne (First, Middle, Ma	Medical	
Maryland	be od o	Be c		sharoon					,	
<u></u>	s 1 and 2 should f Health and Men item 27 is marke other treumetic	ပ	19a. Informant's Name/Relationship		19b. Mailir	a Address (Street		elaide Sh ural Boute Number (	TECKETTS Dity or Town, State, Zin	Code)
<u>∞</u>	d 2 lith a lith a 27 is		Mrs. Judith Disha					Parkvil1	, , ,	
<u>6</u>	item		20a. Method of Disposition	206. 1	Place of Dispo	sition (Name of natory or other place	Ţ		c. Location - City or To	
Baltimore,	9 - 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	JHemovai from State			Corp. 5/2	4/2006	Towson, Ma	ryland
를	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Lice			. Name and Addre		The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	)5 Harford	
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	Pnysician		Immediate Cause (Final disease or condition	18.14-BOD				stage		Onset and Death
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	Examiner		Sequentially list conditions,	b						
	sit sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):					
	and I-trans	Examin	that initiated events resulting in death) Last	c Due to (or as a consec	ulence of):					
8/60,	cate be executed physician and the burial-transit	al E		500 10 (01 00 0 001000	1001100 01).					
280		edical		d						
×	death certifii e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of delive	erv
X R O	death a atter	clai	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		Ectopic pregnancy   Other (specify) _	/		Month	Day Year
o.	at the de by the a tached	hys	9 Unknown	9 Unknown						
ري ح	law requires that the as been signed by th 2 should be detache	by P	Part II. Dther significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
ğ	w require been sig should b							1 🗆 Yes	2 ☐ No 3 ☐ Prob	pably 4 Unknown
Hecords,	aw re	Completed						24a. Was an	24b. Were auto	psy findings available
ř	9 L g	mo						autopsy performe 1 Yes 2	d? death?	mpletion of cause of
Vital	sicien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)		
01 <	physic this ce al dire	To	1 Yes 2 No	Hospital: 1   Inpatient 2	ER/Outpatien	t 3 DOA Oth	er: 4 Nursing H	ome 5 Residenc	ce 6 Other (Specif	N HOSPICE
	ding Ph h. After th funeral	ino i	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	k?	28d. Describe how	injury occurred	
<u> </u>	Attendi death. ctor: A y the fu	catl	2 Accident investigatio				Yes 2 □ No			
DIVISION	or Attendated after deatl	Certification:	4 Homicide determined		ome, farm, str fy)	et, factory, office		City or Town, S	et and Number or Rura State)	I Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certificocompletely filled in by the funeral director,		29a. Certifier 1 Certifying Pl	nysician: To the best of my kno	wledge dose	occurred at the time	no date and place	and due to the ac-	ea(e) and manage = -	tatad
	24 ho Fun etely	edical	(Check only 2 Medicel Exer	niner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my o	pinion, death occu	rred at the time, date	se(s) and manner as si and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0 0		29c. Licens	e number	29d	. Date signed (Month,	Day, Year)
	- s ⊢ ō		Dondoon	12 Hraco 00	011-	りみ	5642	0	5/21/2	006
1	2+1		30. Name and address of person who	completed cause of death (Iter	n 23a) (Tvpe.	Print) Labo	IN.CI	RLES STRE	/ / -	~
	5		Kerdoll R Faulk		., (., )	Ton	SON MI	2/204		
	s Sta	te	31. Date filed (Month, Day Year)	32. Régistrar's Signa	ature	brack &	- Julius	/	······································	
•	Registr		MAY 2 4	ZUUO	55° A	No. of Street, or other Persons.				

		-	For State Registrar	• •		id / Depa		lealth and M Death	Mental Hy		06	163	31
			Decedent's Name (First, Middle, La.	st)					2. Date of De.	ath Day	Year	3. Time of D	Death
	Physicia /Medic	al	Cora Lee Eldri						May 9	2006		0048	A ^M
	Examin		4a. Facility Name (If not institution, give		iber)			or Location of Death			unty of Death		
			Holy Cross Hosp: 5. Social Security Number 6. S		7. Age (In yrs.	last hirthday)	Silver If Under 1 Year	Spring If Under 24 Hrs.	8. Date of Birt		ntgome 9. Birth	ry place (State or intry)	Foreign
	Funeral Director			_M 2XF	96	Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da Aug • 6	y, Year) 1909	Vi	ntry) rginia	
	D		Usual Residence of Decedent						·			10d. Inside City	v Limite
	anylan show	-	10a. State 10b. County			ty, Town or Lo	cation					1 Tyes	133
	he Mi	Director	Virginia Buckingl	nam	Dı	11wyn	10f, Zip Code			10g. Citizen	of What Cou	intry?	
	with t		Route 1, Box 4200	)			23936			U.S.A			
	death ms 23	Funerai	11. Marital Status	12. Was Dece Armed For	dent Ever in U	I.S. 13.		Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No		Race - Amer Black, White		
ထွ	within 72 hours after death with the Maryland ene. Than "natural", or Itams 23a or 28a-f show Ta Maryloal Examities must be notified at		1 ☐ Never Married 2 ☐ Married	1 Tes	2 📉 No		i Tes, specify Cub I ☐ Yes 2 🕅 No		, rilouri, oto.,		ecify: B1a		
93	ural',	d by	3 XWidowed 4 □ Divorced	Year or Da	ates:	162 Dogg	ient's Usual Occup	nation			of Business/li		
7	n 72 h	Completed	15. Decedent's E (Specify only highest gra	de completed)		(Give	kind of work done  OO NOT use retire	during most of work  id)	king	TOD. Tand	01 00011100011	duotiy	
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, p	e filec al Hyg otha vant,	Bec	17. Father's Name (First, Middle, Last	)				18. Mother's Nam			mame)		
<u>a</u>	Menta Menta arkad	10	Robert C. Lee					1	y Chambe				
Marvland 21215-0036	2 short and lamin		19a. Informant's Name/Relationship (					and Number or Rui				p Code)	
	1 and Health am 27 ther t		Zannie Miller  20a, Method of Disposition	(Daughte	20b. I	Place of Disoc	sition (Name of		Date		ion - City or T	own, State	
Baltimore.	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Heatlib and Mental Hygiene. Important: If time 27 la marked other than "natural; or Itams 23a or 28a-1 show any injury or other traumatic evant, the Madical Examiner must be notified at once.		1  Burial 2  Cremation 3  C  4  Donation 5  Other (Specia		State Ba	ptist	natory or other pla Inion Baj	Stist 5/1	3/06	Dillw	yn, VA		
=	nit. P artme ortan injur.		21. Signature of Funeral Service Lice		Ton		emetery Name and Addre	ess of Facility uneral Hor			<i>J J</i>		
ů,	permil Depar Impor		Lennis	Pillm	ear		Highway 1	15 N., P.(	O. Box 2	247 <b>,</b> D	illwyn	, VA 23	3936
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cone cause on e	aused the dea ach line.	th. Do not ent	er the mode of dyi	ing, such as cardiac	or respiratory a	rrest,		Approximate Interval Betw Onset and D	veen
	Physician		Immediate Cause (Final disease or condition	FR	CTURE	01	Hip					Onset and D	- Catil
	/Medical Examiner		resulting in death)	Due to	or as a consec	quence of):							
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() x 68	The law requires that the death certificate to has been signed by the attending physologe 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn	nancy				230	I. Date of deli	very	
Pox Box	death a atter d for u	iciar	in the past 12 months?	4□Pregr	inth 2 Tet ant at time of		_Ectopic pregnanc _ Other (specify) _	>y 			Month	Day Y	'ear
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axa to ME	ires that the d signed by the	by	Part II. Other significant conditions  ALSEX 10 SCURP	contributing to d	eath but not re	sulting in the u	nderlying cause gi	iven in Part I.				the cause of de bably 4 🗆 U	
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$\approx$	n: Th ficate n: pag		25. Was case referred to medical	1				26. Place of Dea	1 Yes		1 ∐ Yes	2 No	
在 \$	rstcia s certi	To Be	examiner? 1 ☑ Yes 2 ☐ No	Hospital:	Inpatient 2	X ER/Outpatie	nt 3 DOA Ot		ome 5 Res		Other (Spec	ify)	
Ž	g Phy ter thii		27. Manner of Death	28a. Date (Mon	of Injury th, Day Year)	28b. Time of		ury at ork?	28d. Describe	how injury o	ccurred		
.5	andin sath. or: Af	atic	1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not	on 4/11,	/06	Unk		]Yes 2∭No	Fell I				h
Faxed to ME	or Att	Certification;	3/□ Suicide 6 □ Could not determined	build	e of Injury - At I ing, etc. <i>(Sp</i> ec Home	home, farm, st :ify)	reet, factory, office	•	RGYu4 €	wr State	O. Box	ral Route Numb 4200	per,
	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier 1 ☐ Certifying P	hysician: To the	hest of my kn	nowledge, dear	h occurred at the	time, date and place	and due to the	cause(s) an	23936 d manner as	stated.	
	a Hos 24 hc e Fun letely	edicai	(Check only 2 Medicel Exe	miner: On the b	asis of examin	nation and/or in	ivestigation, in my	opinion, death occu	rred at the time,	date and pl	ace, and due	to the cause(s)	1
	To th within To th comp	Me	29b. Signature and title of certifier	1				rse number		/	igned (Month	, Day, Year)	
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	(h)		30. Name and address of person who					iko #211	Rookari	11e M	m 2085	i2	
1			Carl Margolis, 31. Date filed (Month, Day, Year)					ike #211,	NOCKVI	11C, 1	TD 2002		
	St Regist	ate rar	MAY 2 4	2006		A.A	1						
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			For State Registrar	State of M	Maryland		artment <i>tificate</i>			nd M	ental H	ygie Reg.	201	16	16332
3		_	1. Decedent's Name (First, Middle, Last	)							2. Date of D Month	eath	Day	Year	3. Time of Death
	Physicia /Medic		Effie	S	•	Fre	derick	τ			May 1	9,	2006		1:45 a M
	Examin	155	4a. Facility Name (If not institution, give	street and numbe	or)		4b. City, To	own, or l	Location of	Death			4c. County of	of Death	
		. 1	Continuum Car						ykesv				Car	roll	
	Funeral		5. Social Security Number 6. Se	x 7 □M 2⊠F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of B	ay, Ye	ear)		lace (State or Foreign ntry)
	Director		214-20-1612	J.W. 2001	80	115.					June 2	.0,_	1925	Mai	ryland
	and	-	Usual Residence of Decedent  10a. State 10b. County		10c. City	r, Town or Lo	cation							1	0d. Inside City Limits
	Aaryli sho	ō	MD Balti	m 0.16 0		Hu	at Va	11e	7						1 ☐ Yes 2 ☐ No
	28a-	Director	MD Balti  10e. Street and Number	шоге		nu.	10f. Zip C		<u>y</u>			10g.	. Citizen of W	hat Cour	ntry?
	with with	۵	8 Spring Gree	n Lane				2	21030				U.S.A	Δ	
	heath ms 2%	era	11. Marital Status	12. Was Decede		S. 13.	Was Decede			in? (Spe	ecify Yes or h	10-	14. Race	- Americ	an Indian,
<b>'</b> O	Ther of	Funerai	1 Never Married 2 Married	Armed Force		1				Puerto	Hican, etc.)			k, White,	etc.
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21215-0036	72 hours after death with the Maryland Insture!, or Items 23s or 28s-1 show oreal Examiner must be nutified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation			dent's Usual kind of work			of worki	na	16b	b. Kind of Bu	siness/In	dustry .
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2	filed wi Hygien ther th	Cor		1		Tele	phone			1 1	/C'	1- 44-3			elephone Co
D		Be	17. Father's Name (First, Middle, Last)						18. Mother				iden Sumam		
<u>×</u>	2 should be and Mental Is marked (	ို	Raymond	Sentz		T					11ian		Love1		
Maryland	ges 1 and 2 should t of Health and Men If item 27 Is marke or other traumatic		19a. Informant's Name/Relationship (7			1						- 70	ity or Town, s		
	1 and 1 Health tem 27		Linda F. Lewis D	aughter	20h P	8 Spr			Lane		nt Val	_	MD c. Location - 0	2103	
9	Pages 1 ar		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐	Removal from Sta	ite C	emetery, crei	natory or oth	her place							
Ë	tmen tent:		4 □ Donation 5 □ Other (Specify		Kri	iders		-		5/22					, Maryland
Baltimore,	permit. Page Department of Importent: If sny injury or once.		21. Signature of Funeral Service Licen.	11 10 11	V.								rstown		
	202 * 0		23a. Part1. Enter the disease, or comp	11 Jest	1410		LINE F							Mary	/land 21136 Approximate
			shock, or heart failure. List only	one cause on each	n line.	i. Do not en	er me mode	or dying	, such as t	Jarurac (	or respiratory	anest	,		Interval Between Onset and Death
	Physician		tmmediate Cause (Final disease or condition resulting in death)	a	1590	ens	نح	1)(	760		Q				
	/Medical Examiner		Toolking in dodding	Due to (or	as a consequ	uence of):	. / .	20 10	. 6	12					
	*	-	Sequentially list conditions,	b. Due to (or	as a consequ	nence of):	rre	211	176	UN	<i>¬</i> ,				
	ed sit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	B = 1	200	1	Tak	Eã	7						
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8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burral-transit														
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×	eath certific attending p I for use as I	/Me	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome									23d. Date	e of delive	ery
Box	atter   for u	ciar	in the past 12 months?		t at time of d		∃Ectopic pre ∃ Other (s <i>pe</i>						Mor	nth	Day Year
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<u>α</u>	that ned by deta		Part II. Other significant conditions of	ontributing to deat	h but not res	ulting in the u	nderlying ca	use give	n in Part I.		23e. Di	d tobac	cco use contr	ibute to t	he cause of death?
ds	uires n sign Id be	d by	Dehr dras	WDI	~						10	] Yes	2 DNO	3 🗌 Prob	oably 4 Unknown
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ā	ician: Th certificate rector, pag	e Cc	25. Was case referred to medical			031	200			of Deat	1 ☐ Yes		No 1	☐ Yes	2 No
⋚	Physician: r this certifica ral director, i	00	examiner?	Hospital: 1 🔲 Inp	atient 2	ER/Outpatie	nt 3□ DO/	Othe					e 6 □Othe	er (Specif	6/1
of	ding Physician: The n. After this certificate hit funeral director, page	. To	27. Manyer of Death	28a. Date of (Month,		28b. Time o		Bc. Injury Work					injury occurr		,,
on	ding F th. : After s funera	tio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	м		? /es 2 □ 1	No					
Division	or Attending after death. Director: After in by the fune	fice	3 ☐ Suicide 6 ☐ Could not be	280. Place of	Injury - At ho	ome, farm, st	reet, factory,	, office			28f. Location City or 1	(Stree	et and Numbe	er or Rura	al Route Number,
Ö	al or A safter Il Direct	Certification;	4  Homicide	building	, etc. (Specif	у)					City of I	Own, 2	olate)		
	To the Hospital or Attsnowihin 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Ph												
6	n 24 n 24 hs Fi	Medical	(Check only 2 Medical Examone)	and manne		ition and/or ir	ivestigation,	in my op	inion, deal	in occur	red at the tim	e, date	and place, a	ina que i	o the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	. /			29c.	License	number			\ ^{29d}	. Date signed	(Month,	Day, Year)
			Philit B	Keo	who we	121		111.	423	3	4	211	210	0.	
			30. Name and address of person who	completed cause	of death (Iten	n 23a) (Typę	Print)		, ,	_	1 00				
-			4000 019	310.	SU	-	150	20 C	7 (	70	46	3	00		
	St Regist	ate	31. Date filed (Month, Day, Year)  MAY 9. 4.2006	32. Reg	istrar's Signa	ature									
	negist	ग्या	MAY Z 4 ZIBIB	1 - 19 FA 12	De Santo	and the same									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 8 per fh 2855 5-24-06 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day-H Year FOWLER 5:55 PM ELIZABETH MAY 18 2006 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE. CENTER RANDALLSTOWN HOSPITAL NORTHWEST If Under 1 Year If Under 24 Hrs. 8. Date of Bight (Month, Day Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 ☐ M 2 🔀 F 319-22-7028 Usual Residence of Decedent 80 MD 03/46/1904 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No NA Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number N. Dukeland USA SH 21216 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ₺ No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry 10th Grade NA elevator operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eldrige Bowie Elizabeth Holland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ace of Disposition (Name of Date 20c. Location - City or Town, State William Fowler 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Scremation 3 ☐ Removal from State 5/20/2006 Baltimore, MD Greenmount 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility e Funeral SVC Youghn C. Greene Funeral SVC 5151 Batto. Natt. P. Ke, Battimore, MD 21229 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCINOMA OUARIAN Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Tho Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown MALIGNANT OBSTRUCTIVE JULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an CHRONIC autopsy performed? Yes 2 (No PRIERY PISEASE CORDNARY 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural
2 Accident 5 ☐ Pending 1 Yes 2 No investigation 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

/Medical Examiner use as the burial-transit The law requires thet the death certificate be executed P.O. Box 68760,< φ ned by the a Records, been signe should be of Vital Division

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Physician

/Medical

Examiner

10a. State

1408

Directo

Funerai

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Be Completed

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be codified at once.

Physician

Examiner

Completed by Physician/Medical

Be

2

Medical Certification;

29a. Certifier

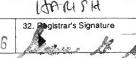
Baltimore, Maryland 21215-0036

State Registrar

AVYERABALLI 31. Date filed (Month, Day, Year) MAY 2 4 2006

29b. Signature and title of certifier

aville



Ploysici Ad

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Butto

11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

5401

42723

NORTH WEST

29d. Date signed (Month, Day, Year)

18

2006

CENTER

MAY

BOSPITAL

OLD COURT ROMD

			For	State of Ma	aryland / Dep		lealth and M		ene	16001.
			State Registrar		Ce	rtificate of l	Death	Reg	. No U U C	
	Physici	an	1. Decedent's Name (First, Middle Stephen	Robert	Cn:	bus		Month	Day Yea 20.	
	/Medic Examin		4a. Facility Name (If not institution				Location of Death	May	20, 200 4c. County of De	
	LXamiii	C1	1112 South C	linton Str	eet	Balt	imore		n/a	
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )	ear)	Birthplace (State or Foreign Country)
	Director		213-09-1895 Usual Residence of Decedent		88 Yrs.	J, J		Dec19,1	91/ Pe	ennsylvania
	yland how		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	8e-fs	cto	Md. n/a		Ва	ltimore				1√2 Yes 2 □ No
	with the	Dire	10e. Street and Number 1112 South C	linton Ctr	t	10f. Zip Code	1224	100	J. Citizen of What	Country?
	death ms 23	erai	11. Marital Status	12. Was Decedent		Was Decedent of H		ecify Yes or No-		merican Indian,
9	or ite	Fur	1 Never Married 2 Marri	Armed Forces?  ied 1 [] Yes 22[]  If Yes, Give	No	If Yes, specify Cuba 1☐ Yes 2☐vNo	in, Mexican, Puerto  Specify:	Rican, etc.)	Black, W	
003	hours urel',	d by	3√ Widowed 4 □ Divorced	Year or Dates:				1 44		White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "naturel", or items 23a or 28e-f show uther than "naturel", or items 23a or 28e-f show it, it is M. Greal Examiner must be mobiled at	Completed by Funeral Director	15. Decedent (Specify only highes	st grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work f)	ing	6b. Kind of Busines	ss/industry
212	d with giene er tha	Com	Elementary/Secondary (0-12)	College (1-4or		teel Wor	cker		Beth	Steel
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle,					e (First, Middle, Ma	iden Sumame)	
yla	d Men marke	2	Andrew Gnib  19a. Informant's Name/Relationsl		10b Maili	ing Addross (Stroot	Anna I		City of Town State	e, Zip Code) 21638
Maryland	nd 2 si Ith an 27 is r		Carolyn M. U							
re,	item		20a. Method of Disposition			osition (Name of matory or other place			c. Location - City	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or items 23a or 28e-f show appringing or other treumetic event, Itie M. dical Examiner matter notified at once.		1 ∑Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (S		Sacred He	eart of Je	esus May			, Maryland
3alt	Depart Depart Import eny inj		21. Signature of Funeral Service	icensee	1	2. Name and Addres	ss of Facility Kac	zorowsk	i Funer	al Home, PA
	40300		23a. Part1. Enter the disease, or	amplications that caused		201 Dund				Approximate
-	Priysician		shock, or heart failure. List	only one cause on each li	ne.	·	•	. ,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as	a consequence an):	1				
B	Examiner	_	Sequentially list conditions, if any, leading to immediate	b. Scd	carlo	larles	ller	OMID		1
	nsit Med	nine	Cause (Disease or injury	Due to loras	A prints and ance. Th	0,000				
Ć,	te be executed ysician and e burial-transit	cai Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):					
3760,				d						
x 68	death certificate be attending physical for use as the t	Physician/Med	IF FEMALE:	220 If you outcome	of prognancy					
Вох	attenc for us	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant a	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of d Month	Day Year
o.	that the death led by the atter detached for i	hysi	1 Yes 2 No 9 Unknown	9□ Unknown		\ \ \ / /				
s, P	es tha igned l	by P	Part II. Other significant condition	ons contributing to death b	out not resulting in the u	underlying cause give	en in Part I.			to the cause of death?
ord	requir een s nould							-	2 No 3	
Record	e lav has je 2	Completed						24a. Was an autopsy performe	24b. Were prior to death	autopsy findings available to completion of cause of ?
Vital		e Co	25. Was case referred to medical				26 Place of Deat	1 Yes 2 (Check only one)	No 1□Y	es 2 <b>/10</b> No
fVi	N S ID	To B	examiner? 1 □ Yes 2 🏋 No	Hospital:	ent 2 ER/Outpatie	nt 3 DOA Oth		me 5 Residen		pecify)
n of	ing Pt Viter th		27. Manner of Death 1 ☑Natural 5 ☐ Pendin	28a. Date of Inju (Month, Da	ury 28b. Time of Injury	Worl		28d. Describe how	injury occurred	
Division	Attending r death.	icati	2 Accident investig	not be 290 Piaco of In	jury - At home, farm, st		Yes 2 □ No	28f. Location (Stre	et and Number or	Rural Route Number,
Σ	al or A after I Dire d in by	Certification:	4 Homicide determ	building, et	c. (Specify)			City or Town,		
	To the Hospital or Attanding Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical	g Physician: To the best Examiner: On the basis of						
	the H	Medi	one) 29b. Signature and title of certifie	and manner st		29c. License			I. Date signed (Mo	` '
	wit Con			200	NOD	20	5734		1/22	101
	1-		30. Name and address of person	who completed cause of c	leath (Item 23a) (Type	(Print)	0.	1		
	Y		S-kuch &	LONGAN	1310	Y-Ces	Her	1000	au 1	71121226
	Sta Registi		31. Date filed (Month, Day, Year)	4.1.7.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.	rar's Signature					
				- 49						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month sent Physician 10:30 PM ornelia 2006 21 /Medical 4b. Oty, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner BALTIMORE Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 23, 1922 7. Age (In yrs. lest birthday) 5. Social Security Number Birthplace (State or Foreign Country) Funeral 1 □ M 2 🖸 F 83 Vrs Pennsylvania 218-18-9143 Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or flems 23a or 28a-f shor traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Parkville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 8810 Walther Blvd. Apt 2028 21234 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No If Yes, Give 1 943-1944 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married natural, or 1 ☐ Yes 2 ☐ YNo Specify: ģ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Immigration Official U.S. Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) and Mental Albert. Ε. Clawson Eloisa Barreiro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nancy G. Baldwin Daughter 8408 Charles Valley Court Towson, Maryland 21204 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-23-2006 Hilltop Service Corp. Maryland Towson 22. Name and Address of Facility 21. Signature of Figneral Service Licensee Ruck Towson Funeral Home, Inc. 21204 1050 York Road Towson, Maryland tagap 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner ettending physician end to for use es the bunel-trensit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. by Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown rthis certificete has been signed iral director, page 2 should be de 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 NO 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours e To the Funeral C completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. edicai 29a. Certifier To the 29b. Signature end title of certifier 29c. Nicense number 29d. Date signed (Month, Day, Year) 06 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 21234 1041 Burnentha tu 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar MAY 2 4 2006 1804 **ORIGINAL** 

**DHMH 16 Rev 6/95** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) ₫2006 MAY 21, **Physician GURNEY** 7:08 P MORTON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HOSPICE OF BALTIMORE GILCHRIST CTR. BALTIMORE TOWSON If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Month Day Year 16 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months 1 M 2 □ F 89 NJ 215-01-8242 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other traumatic event, the Medical Exercises must be notified at 1 ☑ Yes 2 ☐ No Director MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7219 PARK HEIGHTS AVENUE #302 21208 USA death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: WHITE þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWNER REAL ESTATE 12 should be filed w and Mental Hygier Is markad othar th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SOLOMON **GURNEY** SARAH SHILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh
Department of Health and
Important: If itam 27 Is m
any injury or other traum 7219 PARK HEIGHTS AVE. #302 - BALTIMORE, MD 21208 ROSE GURNEY / WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ANSHE EMUNAH (AITZ CHAIM) 5/23/06 HALETHORPE, MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. of Funeral Service Licen 21. Signatu 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Privsician /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ brillation 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death a Hospital or Attanding P 24 hours after death. a Funaral Diractor: After t 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital a within 24 hours at To the Funerel D

Division of Vital Records, P.O. Box 68760.

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

32. Registrar's Signature

30. Name and address of person who completed caus of death (Item 23a) (Type, Print)

1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

025205

6601 N. CHARLES TREET

Towson MD 21204

29d. Date signed (Month, Day, Year)

MAY 22, 2006

1

mo

			State of Maryland / Department of Health and M  Stete Registrar  Certificate of Death	Re	g. No.	16337
	Physiciar /Medica	1	Decedent's Name (First, Middle, Last) Florence L. Hubbard	2. Date of Death Month May	Day Year 22 2006	3.03 IM
	Examine		A. Facility Name (If not institution, give street and number)  Ruxton Rehabilitation  Social Security Number  16 Sex 7 Age (In vrs. last birthday)  If Under 1 Year If Under 24 Hrs.		Baltimo	re
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 81 Yrs. Social Security Number 2 2 7 - 2 0 - 8 9 7 6 1 M 2 F 81 Yrs. Social Security Number 1 Months 1 Min.	8. Date of Birth (Month, Day, 11-12-	Year) 9.80 1924 Vi	rthplace (State or Foreign country) rginia
	Maryland -f show fled at		Maryland Baltimore Reisterstown			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the	Funeral Director	10e. Street and Number 21136	10	Og. Citizen of What C USA	country?
38	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or items 23a or 28e-f show any injury or other treumetic event, ITs Madical Express. That is profiled at once.	by runer	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes, Sive 1 Yes, Give 1 Yes, Give 1 Yes 2 No 1 Yes, Give 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: B	
Maryland 21215-0036	within 72 hou ane. then "neture the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1 Agr 5+)  College (1 Agr 5+)  College (1 Agr 5+)  Nurse S Assistant	ing 1	Hospital	s/Industry
/land 2	Mental Hygie arked other atic event, II	lo Be Co	17. Father's Name (First, Middle, Last)  William Lewis  Mollie	Jennin	gs	
, Man	and 2 sho salth and I n 27 is ma		19a. Informant's Name/Relationship (Type, Print)  Patricia A. Davis daughter  14 Panacea Court Pi	ikesvil	le, Md 2:	1208
Baltimore,	Pages 1 ment of He ent; If iten ury or oth		1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) Woodlawn Cemetery 5-26	-2006		, Maryland
Balt	permit. Departr Importa		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wy ]			
	Physician /Medical		23. Part 1. Effer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Affector osclerofc Coudiova scurrent resulting in death)			Approximate Interval Between Onset and Death
8	Examiner	er	Due to (or as a consequence of):  Sequentially list conditions, If any, Leading to immediate  Due to (or as a consequence of):			
/ee/ _e		Ical Examiner	causé. Énter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
OSPN- O. Box 687	attending p for use as	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   4   Pregnant at time of death 5   Other (specify)   9   Unknown   9   Unknown   1   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   Vertical Pregnant   V		23d. Date of de Month	elivery Day Year
ds, P.	gner gner be d	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Na-Hods Ken's Lymphona			to the cause of death?
al Record	as b	Completed	chronic lung disease	24a. Was ar autopsy perform 1 \( \text{Yes} \) 2	y prior to	autopsy findings available completion of cause of
of Vit	Jing Physicien: T. After this certific funeral director,	To Be	examiner? 1		e) ince 6 ⊡Other ( <i>Sp</i> w injury occurred	ecify)
Division		Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town		
30	the Hospitel nin 24 hours a the Funerel npletely filled	Medical	29a. Certifier  (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time, da	ate and place, and du	e to the cause(s)
	or Milit		Mendall RFaller D25643		9d. Date signed (Mor	2006
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kendall Proukner MD/6765N. Charles & Sucufe  31. Date filed (Month, Day, Year)  32. Registrar's Signature	209/B	alto Mi	21204
	Stat Registra		31. Date filed (Month, Day, Year) 32 Registrar's Signature			

			For State Registrar	State	of Marylar		artment of rtificate of		nd Men		giene, Rag. No.	2006	16338
			1. Decedent's Name (First, Middle	, Last)						Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		CHARLES	W		HOFFM	AN					2006	9:08 A M
y	Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, Town,	or Location of [	Death		4c. (	County of Death	1
			5129 Mountair					asadena	111				Arundel
	Funeral		5. Social Security Number	6. Sex 1 M 2 ☐ F	7. Age (In yrs.	. last birthday) Yrs.	Months Days	r If Under 24 Hours	Min.	Date of Birt Month, Da	y, Year)	Cot	nplace (State or Foreign untry)
	Director		220-20-9030 Usual Residence of Decedent		79				F	eb. 7	, 192	/ Ma:	ryland
	/land		10a. State 10b. County		10c. C	ity, Town or Lo	ocation						10d. Inside City Limits
	Man	to	Maryland Ann	ne Arunde	1 P	asadena	1						1 ☐ Yes 2 No
	h the	<u>ie</u>	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Cou	untry?
	th wit	Funeral Directo	5129 Mountain F	Road				21122				U.S.A.	
	r dea	neu	11. Marital Status	12. Was De Armed F	cedent Ever in U orces?	J.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin ban, Mexican, F	n? (Specify Puerto Rica	Yes or No-	- 1	<ol> <li>Race - Amer Black, White</li> </ol>	
20	s afte	by F.	1 Never Married 2 Marr	If Yes, G	2 □ No live		1 ☐ Yes 2 🗷 No	Specify:				Specify: T	Jh: + a
Ö	ilied within 72 hours after death with the Maryland Hygiene. Ither than 'natural', or Itame 23a or 28a-f show ent, Ira Medical Examinar must be notilied at	b D	3 ☑ Widowed 4 ☐ Divorced	Year or	Dates:	16a Dece	dent's Usual Occi	ination			16h Kin	d of Business/I	White
C	in 72 i "na le dic	lete	(Specify only highes	t grade completed		(Give	kind of work don.	a during most o	of working				·
212	iene.	Completed	Elementary/Secondary (0-12) 12	College N	(1-4or 5+) A	Mecha   Troub	nical E. leshoote	lectrica er	aı		Stee	el Manu	factoring Co
0	Hyg other	Bec	17. Father's Name (First, Middle,	Last)				18. Mother's		rst, Middle,	Maiden 5	Sumame)	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. I the Marylan flem 27 is marked other than "natural", or itame 23a or 28a-f show other traumatic event, I'm Meulcal Examicar must be notified at	To B	Jules			Hoffn	nan	Eliza	abeth			Te	llaksen
ary	should have		19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address (Stree				er, City or		
Σ	l and 2 fealth a im 27 la		Arthur R. Posk	ocil (Br			Cavalie	er Drive		noke _	Vir	inia 24	4018
ore	of He		20a. Method of Disposition  1   Burial 2 □ Cremation	3 □Removal from	- 1	Place of Dispo cemetery, crei	sition (Name of matory or other pl	ace)	Date		20c. Loc	ation - City or T	Town, Slate
Ĕ			4 Donation 5 Other (S			mmanue1	Cemeter	cy 5/	/25/06	5_	Ba1	Ltimore,	Maryland
Baltimore,	permit. Pag Department Important: any injury c		21. Signature of Funeral Service	Licensee		2: N	Name and Add	ress of Facility	k Fune	eral I	Tome	РΔ	
	2012 9		11 to	bli			lcCu11y-I 3204 Mour					laryland	
			23a. Park. Enter the disease, or shock, or heart failure. List	complications that only one cause on	each line.		·	1.7					Approximate Interval Between Onset and Death
1	nysician	1	Immediate Cause (Final disease or condition	-a. Ar	teri	0501	lero ti	c/1/	PArt	- /	215	CASE	Criser and Death
	/Medical Examiner		resulting in death)	Due to	o (or as a conse	quence of):							
	_xamme.	L.	Sequentially list conditions	b. Dug to	o (or as a conse	guanca of):							
14	led sit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Z Due in	(Or als a Corise	querice oi).							
,	xecul and al-trar	Examin	that initiated events resulting in death) Last	c	o (or as a conse	quence of):							
8760	cate be executed physician and tha burial-transit	dical E											
89	tificate ig phy as tha	edic		0		.,					5 1	Ī	
Вох	death certific e attending p od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		75-1				2:	3d. Dale of deliv	very
	Q 00 Q	icia	in the past 12 months? 1 □ Yes 2 □ No	4□Preg	birth 2 ☐ Fet nant at time of		∃Ectopic pregnan ∃ Other (specify)	cy				Month	Day Year
о. О	that the di ed by the detached	hys	9 🗆 Unknown	9□ Unk	nown								
S,	The law requires that the site has been signed by the bage 2 should be detache	by F	Part II. Dther significant condition	ons contributing to	death bul not re	sulting in the u	nderlying cause g	iven in Part I.		23e. Did to	bacco us		the cause of death?
Ž	w require been si should I	De le							_	1 🗆 Y	/es 2 □	No 3∏Pro	bably 4 AUnknown
ပိုင်	law ri as be 2 sh	ple								24a. Was autop	SV	24b. Were aut	opsy findings available ompletion of cause of
<u> </u>	The ate h page	Completed								perfor	rmed? 2 No	death? 1 ☐ Yes	2) No
/ita	Attending Physician: r death. ector: After this certifici by the funeral director,	Be (	25. Was case referred to medical examiner?					26. Place of	f Death (Cf	neck only o	ne)		
5	hysi this c	၉	1 XYes 2 No			ER/Outpatier	IL SEL DON					Other (Spec	ify)
Ĕ	ing F After unera	-io	27. Manner of Death 1 ■ Natural 5 ■ Pendin	9	nth, Day Year)	28b. Time o Injury	W			Describe h	ow injury	occurred	
Sic	ttendi death ctor: / the fu	cat	2 Accident investig	not be	o of Injury - At h	nome farm et	M 1[	]Yes 2□No		Location (S	Street and	Number of Pu	ral Route Number.
Division of Vital Records,	after after Direction by	Certification:	4 ☐ Homicide determ	ined 289. Flat	ding, etc. (Spec	ify)	eet, factory, office	•		City or Tow		Nulliper of Hur	al Houle Ivamber,
_	pital ours neral filled		29a. Certifier 1 ☐ Cartifyin	g Physician: To the	e best of my kn	owledge deat	h occurred at the	time date and r	place and	due to the	cause(s) a	and manner as	stated
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Madical one)	Examiner: On the	basis of examin	ation and/or in	vestigation, in my	opinion, death	occurred a	t the time,	date and	place, and due	to the cause(s)
	vithin Fo th	Me	29b. Signature and title of certifie	r	De	ou te	1 29c. Licer	nse number			29d. Date	signed (Month	Day, Year)
			1 /dille	-PC	200	mr	D	060	54		4	5/23	106
	141		30. Name and address of person	who completed on	use of death (Ite	m 23a) (Type,	Print)		1			1	
1	1 10		William	PI	ones,	my	7 10	95	Am	eric	CA	210	35
	Sta		31. Date filed (Month, Day, Year)	32.	Registrar's Sign	ature	af a		,				
	Registr	ar	MAY 2 4 21	106 Alas	1500 JEA	65054	Sal Sal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** GAYLE 0710 AM 2000 HENRY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland
5. Social Security Number 6. Sex 7. Medical Ce 100 hmore Year If Under 24 Hrs. 8. Date of Birth
Davs Hours Min. Month, Day, 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 **Funeral** Days Months 1 ☐ M 2 🛛 F 219-72-6752 Director ana ary Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits or 28a-f show ortant: If item 27 is marked other than "naturel", or items 23s or 28s-1 sho injury or other traumatic event, If a Madical Exaction mast be notified at 1 Tes 2 No Director TMOVE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21223 2142 U.S. A Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. ☐Yes 2XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black <u>6</u> If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working flife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) eeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ onald Delores Jones 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship palo, Md, 21217 ores mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City of Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Ballo. permit. Page Department of Important: If eny injury or once. 5-30-2006 4 Donetion 5 Dother (Specify) Al Many and Address of Pagili 21. Signature of Funeral Service Lice Batti. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 3-5-days disease or condition resulting in death) Preumonia

Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the funeral director, page 2 should be breast 1 Yes 2 No 3 Probably 4 20 Inknown concer Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funaral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 8574 23, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date liled (Month, Day,

Consta

S. Gree

Registrar's Signature

				for State Registrar	State o	f Mary	/land / [	Departm <i>Certific</i>		lealth and <i>Death</i>	Mental Hy	ygiene	7 U U D	16340
		0		1. Decedent's Name (First, Middle, Las	t)						2. Date of D	eath Da	v Year	3. Time of Death
		Physici /Medio		Mary Evelyn Hens	ley						May	20	2006	6:40 p.M
		Examin	er	4a. Facility Name (If not institution, give	street and nu	mber)				or Location of Deat	h		. County of Death	
				Gilchrist Center		7 A (I-			TOWSOI		O Data of B		altimore	
	ш	Funeral		5. Social Security Number 6. Se	ox □M2XXTF		n yrs. last bir		ths Days	Hours Min	(Month, D	lay, Year)		place (State or Foreign intry)
		Director		216-52-0335 Usual Residence of Decedent		56_					Aug.	13,	1949 Ma	ryland
Pr		yland 10w		10a. State 10b. County		10	c. City, Tow	n or Location						10d. Inside City Limits
		the Marylan 28a-f show	Ş	Marvland Harfor	rd.		Edgew	boc						1 Yes 2 No
07		or 28	Director	10e. Street and Number				10	. Žip Code			10g. Cit	tizen of What Cou	intry?
		ath with the Maryla 23a or 28a-f show	ral	617 Wingleaf Cour					21040				ted Stat	
9		ter dea items	Funeral	11. Marital Status	12. Was Dec Armed Fo	orces?	r in U.S.	13. Was E	ecedent of I specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or N to Rican, etc.)	lo-	<ol> <li>Race - Amer Black, White</li> </ol>	
	36	rs aft	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Gi Year or □	ve		1 🗆 Y	s 21XNo	Specify:			Specify: Whi	te
	5-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show he Medical Evertiral rust be trufffed at	ed	15. Decedent's Ed	ucation		16a.	. Decedent's	Usual Occu	pation		16b. K	(ind of Business/l	
9	215	hin 73	Completed	(Specify only highest gra	de completed) College (			life. DO No	it work done OT use retire	during most of wo d)	rking			
0	21	e filed within II Hygiene. other than	Com	12 years			D	ispato	her	,		T	rucking	
200	pu	be filed within 72 hours after de ital Pygiene. d other than "natural", or items event, it e Medical Evaninal re	Be (	17. Father's Name (First, Middle, Last)						18. Mother's Na			Sumame)	
0	Maryland	should be fand Mental Hamked of umatic even	2	Bernard Frederick		tt				Mary Jar				
0	lar.		5.3	19a. Informant's Name/Relationship (7	Гурө, Print)					and Number or R				
0	ď	1 and 2 Health tem 27		Joe D. Dixon, III	(So:			807 Ja f Disposition		Road Ba	ltimore Date		ryland 2 ocation - City or 1	
AY	- 2			1 🛱 Burial 2 □ Cremation 3 □			cemete	ry, crematory	or other pla					er, Maryland
H	altimor	- 217		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Licentee</li> </ul>			нотту			ess of Facility	3/2000	PI_LC	are vive	raryrand
2	Ba	permi Depa Impo any ir		A TONA SULLE STATE OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF THE SECOND PROPERTY OF	Mar	~1)	1	Duda	-Ruck	Funeral	Home of	Dun	dalk, Ir	IC.
>			-	23a. Part1. Enter the disease, or com	plications that	causegine	e death. Do			Avenue ng, such as cardia			ryland /	Approximate
				shock, or heart failure. List only Immediate Cause (Final	a. BRE		CALL	Cc 0	und.	metas	tacas			Interval Between Onset and Death
		Pnysician /Medical		disease or condition resulting in death)			onsequence		WITN	-neias	14363		-	5 years
		Examiner		Constally list and divine	b									
	7	₽ ≅	ner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a co	onsequence	of):						
	V	scute, ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c			-4)						
	,092	be executed sician and burial-transit		resulting in death) cast	Due to	(or as a co	onsequence	or):						
	87	cate t	dical		d									
	Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, ou	itcome of p	oregnancy						23d. Date of deli-	verv
		atter affor u	clar	23b. Was decedent pregnant in the past 12 months?	4☐Preg	nant at tim	Fetal death		oic pregnand or (specify) _	y			Month	Day Year
	0	t the de by the tached	hysl	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unkr	iown								
>	۳.	es that igned b	by P	Part II. Other significant conditions of	ontributing to c	leath but n	ot resulting i	n the underly	ing cause gr	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
RY	rd	w require been sig should b									1	Yes 2	□No 3□Pro	bably 4 Unknown
T	ecords,	law re as be	ompleted								24a. Wa	s an	24b. Were aut	opsy findings available ompletion of cause of
ع		The I	Com									formed?	death?	2 □ No
	/ital	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?							ath (Check only	one)		77
>	of \	Physic this co	မ	1 ☐ Yes 2 X No		Inpatient			JOOA		Home 5 ☐ Res		6 Other (Spec	ity) HOSPICE
0		Jing F	lon	27. Manner of Death 1 X Natural 5 Pending	28a. Date (Mor	of Injury	ear) 28D.	Time of Injury M	28c. Inju Wo	ryat irk? ]Yes 2⊡No	28d. Describe	now inju	ry occurred	
SN	ision	death death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not b	e Ogo Plan	e of Injury	- At home, fa	am, street, fa		1700 2 2 110	28f. Location	(Street ar	nd Number or Ru	al Route Number,
õ	Divi	after of Di sc	Cer ification:	4 Homicide determined		ling, etc. (		,	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			òwn, State		
Ť		To the Hospital or Attending within 24 hours after death. To the Funeral Dijector: After completely filled in by the fune	al C	29a. Certifying Ph										
		n 24 l n 24 l ne Fu	edical	(Check only 2 Medical Exer		nasis of ex		nd/or investig	ation, in my	opinion, death occ	urred at the time	, date an	d place, and due	to the cause(s)
,		To the To the comp	Ž	29b. Signature and title of certifier	0 -	/	20		29c. Licen	se number		29d. Da	ite signed (Month	
		3		Kerdall	-10-c	sell	lex	)	η 9	2643		02	1	1006
		4		30. Name and address of person who	completed cau		h (Item 23a)	(Type, Print)	660		ARLES 1D. ZI	204 204		
		St	ate	31. Date filed (Month, Day, Year)			Signature	4	100	30N, //	رے ، ب			
	:	Regist		MAY 2 4 20	06	3018mg	A	Cocalle	1					

DHMH 17 Rev 1/2001

		For Amend #8 Per State Registrar  1. Decedent's Name (First, Middle, Last)		Ce	rtificate c	of Death	2. Date of	Reg. N		3. Time of Death
Physici	an	Theodore Osbor	ne Jacks	on			Month		2006 Year	10:18 p
/Medi		4a. Facility Name (If not institution, give s			4b. City, Tow	n, or Location o			lc. County of Deat	
Examir	er	Southern Maryl		ital	Clint	on		P	rince (	George's
Funeral		<ol> <li>Social Security Number 6. Sex</li> </ol>	7. Age (In	yrs. last birthday) 59 Yrs.	If Under 1 Ye Months Da		Min. 8. Date of (Monti	f Birth n, Day, Yea	ur) <b>1946</b> ^{9. Birt} <del>959</del> Was	hplace (State or Foreign untry)
Director		Usual Residence of Decedent  10a. State 10b. County	10	oc. City, Town or Lo	ocation		Мау	29, T	yyy was	10d. Inside City Limits
-1 show	to	MD P.G.		Forestv						1X Yes 2 No
or 28a Le nati	Funeral Director	10e. Street and Number	- 4202		10f. Zip Cod			1	Citizen of What Co	ountry?
ns 23,	eral	6501 Hil-Mar I	12. Was Decedent Eve	r in U.S. 13.			gin? (Specify Yes o	r No-	14. Race - Ame	nican Indian,
id other than "naturet", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fun	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		If Yes, specify 0 1 ☐ Yes 2 ☐x		, Puerto Rican, etc	.)	Specify: Black	
natura dical E	eted	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dece (Give	dent's Usual Oc kind of work do DO NOT use re	cupation one during most	of working	16b.	Kind of Business/	Industry
than the	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		odian	urea)		рC	Public	Schools
varked other ther vatic event, the N	BeC	17. Father's Name (First, Middle, Last)					r's Name (First, M			
marked matic e	2	William A. Jac  19a, Informant's Name/Relationship (Ty		10h Maili	ng Address /St		or or Rural Route N			Zin Code)
27 Is m r traum		Patricia J. Jac					., Fore			
Important: If Item 27 is marke any injury or other traumatic once.		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place of Disponentery, cre	osition (Name o matory or other	1	Date	200	Location - City or	Town Slate
rtant: njury o		* 4 ☐ Donation 5 ☐ Other (Specify)	Ħ	larmony			5-25-20			
Important: I any injury o once.		21. Signature of Funeral Service License	"law"				Ronald ort Ln.			Fun. Chap. , MD 20695
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the ne cause on each line.	e death. Do not en	ter the mode of	dying, such as	cardiac or respirat	ory arrest,		Approximate Interval Between Onset and Death
sician edical	al s	Immediate Cause (Final disease or condition resulting in death)	Broncho Due to (or as a co		nia					nder/Wi
miner		Sequentially list conditions,		Obstruc	ctive S	Sleep	Apnea			
sit	lner	cause (Disease or injury	Due to (or as a c	onsequence of):						
physician and the burial-transit	Examiner		Due to (or as a co	onsequence of):						
physicis s the bu	dical		d							
attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p	pregnancy	⊒Ectopic pregn	20 ov			23d. Date of del	,
the	Physician/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐Pregnant at tim 9☐ Unknown		Other (specif)				Month	Day Year
igned by be detac	by Pr	Part II. Other significant conditions con	0	ot resulting in the i	underlying cause	e given in Part I.			_	the cause of death?
been si	ted	Hepatic Encepho		h Dulmo	222					obably 4 Unknown
has Je 2	Completed	Right Heart Fai	.ture with	II PUIMO	nar y			Was an autopsy performed′ ′es 2 <b>∑</b> i	prior to death?	utopsy findings available completion of cause of
r death. e <b>ctor:</b> After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Jamitali				of Death (Check			
this aldii	- To	1 ☐ Yes 2 🛣 No  27. Manner of Death	lospital: 1 ☐ Inpatient 28a. Date of Injury	28b. Time of		Injury at	rsing Home 5  28d. Desc		6 □Other (Spe	city)
deam. ctor: After / the funer	atlon	XXVatural 5 Pending 2 Accident investigation	(Month, Day Y	ear) Injury		Work? 1 ☐ Yes 2 ☐			july cocurred	
Olrector: in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, s Specify)	treet, factory, of	fice		ion (Street or Town, St		ural Route Number,
To the Funeral Director: completely filled in by the	Medical Co		sicien: To the best of r ner: On the basis of ex and manner state	amination and/or is						
vithin i	Mec	29b. Signature and tile of certifier	and manner state	-		cense number			Date signed (Mont	
F 0		1 Hahu	- v	ND	D00	55120		May	17, 20	006
10	1000	30. Name and address of person who of Richard Palmer,	mpleted cause of deat M . D . 132	South	ern Av	e., St	e 310 V	ashi	ngton, I	OC 20032
	1 9									

DHMH 17 Rev 1/2001

**ORIGINAL** 

		1 - For State Registrar		Marylan		artmer rtificat				Reg. No 2	06	6347
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Barbara Ann Jo 4a. Facility Name (If not institution,	ones	or)	1 0	4b. City,	Town, or	Location of [	2. Date of De Month	Day 2( 4c. County	006 10	ime of Death
Funeral Director		217-78-2157	METAL A 5. Sex 7 1 □ M 2 X F	47 Age (in yrs. 47	fal last birthday, Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Hrs. 8. Date of Bir Min. 05–20–19	th ly Year) 958	9. Birthplace (S Country) Mary Land	State or Foreign
Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  MD NA		10c. Cit	y, Town or L		imore					ide City Limits
within 72 hours after death with the Maryland ene.  Hen "netural", or Iteme 23a or 28a-f show the Madical Examinar neur the notified at	Completed by Funeral Directo	10e. Street and Number  1149 N. Stricker  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's (Specify only highest Elementary/Secondary (0-12)	12. Was Decede Armed Force d 1  Yes 2 H Yes, Give Year or Date	s? XNo s:	16a. Dece	1 ☐ Yes dent's Usu kind of wo DO NOT u	21 dent of Hi cify Cuba 2X No al Occupa rk done of se retired	Specify: Ition Juring most of	1? (Specify Yes or No Puerto Rican, etc.)	14. Race Blac Specify	USA e - American Ind k, White, etc.	ian,
be filed stal Hygi of other event, I	To Be Co	11 17. Father's Name (First, Middle, Li Robert N. Ray					ekeepe	18. Mother's	Name (First, Middle,	, Maiden Sumam :er		
as 1 end 2 of Health ar of Health ar I Item 27 is		19a. Informant's Name/Relationshi  Delores Ray/ Mothe  20a. Method of Disposition  1 □ Rurial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spa	r B⊟Removal from Sta	te C		w. Bal	timore me of other place	Street	Baltimore, Date	MD 21223 20c. Location -	City or Town, St	
permit. Peg Department Important: If eny injury o		21. Signature of Funeral Service Li		ALD	2	2. Name ar	nd Addres	s of Facility	638 N. Gilmo	Baltimore, r Street I		21217
Physician personned physician physician and physician and physician and the prival-transit	dicai Examiner	23a. Part1. Enter the djafase, or c shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Seve Due to (or b. End Due to (or c. End	as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a c	uence of):  wal  uence of):  fe t	ic_ B Rena	Isci Leei l ×	hemire Disea	* Encept	halopar	finter Onsei	oximate all Between t and Death
ath certific	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta at time of d	Ideath 3	⊒Ectopic pi ⊒ Other (sp				23d. Date Mor	e of delivery nth Day	Year
w requires that the de been signed by the a should be detached f	þ	Part II. Dther significant condition	s contributing to death	but not res	ulting in the u	inderlying o	ause give	n in Part I.		obacco use contr Yes 2 □ No		e of death?
	Completed									rmed?// d	Vere autopsy find rior to completio leath?	
ding Phys	Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no	t he	njury Day Year)	ER/Outpatier 28b. Time of Injury	M 2	28c. Injury Work 1 🔲 \	r: 4 □ Nursi		dence 6 □Othe	ed	
To the Hospital or Attenwithin 24 hours efter deatl To the Funeral Director:		4 Homicide determin	ed 259. Place of building,	etc. (Specif	y) wiedge, deat	h occurred	at the tim	e, date and n	City or Tov	cause(s) and mar	nner as stated	
To the Hospital or within 24 hours effer To the Funeral Dire completely filled in b	Medical	(Check only 2 Medical E.  29b. Signa the and title of ortifier	caminer: On the basis and manner	of examina stated.	SING-	vestigation 290	in my op	inion, death (	occurred at the time,	date and place, a	and due to the ca	
Sta Registr		30. Name and address of person w  NANCHAL  31. Date filed (Month, Day, Year)	Singh,	f death (Item	40	Print) A	RYI	land	Gener	al H	ispita	el_

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 1 Decedent's Neme (First Middle Last) 2. Dete of Death 3 Time of Death **Physician** 21, May 2006 THOMAS KNOLL 8:05 AM GEORGE /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peyton Center - McCready Foundation, Inc. Crisfield Somerset 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) 1924 New Jersey 6 Sex **Funeral** Months Days Hours 1 XM 2 □ F Yrs 143-12-9303 82 Director March 1, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at YYYes 2 No Directo Maryland Somerset Crisfield 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 Hall Highway 21817 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 ☑ No Specify: ò Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled Health and Mental Hygidem 27 is marked other 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ John Knoll Agnes Gallagher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 534 Bay Hill Drive - Avon Lake, Ohio 44012 Department of Health Important: If item 27 Annie Gregory (Sister) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) alisbury Crematory 5/23/06 Salisbury, Maryland 22. Name end Address of Facility 21. Signature of Funeral Service Ligense Bradshaw & Sons Funeral Home Yaykotk Bulsku k ary Beth Bradshaw-Pruitt Mary Beth Bradshaw-Pruitt 306 W. Main Street - Cristical Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 306 W. Main Street - Crisfield, Maryland 21817 Approximate Interval Betw Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical CORONARY AMERO SCLENOSIS Examiner Due to (or es e consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of end Division of Vital Records, P.O. Box 68760, physician Physician/Medical Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 D No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 2 12 No 1 ☐ Yes 1 ☐ Yes 2 TNo certificate ector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 2 No Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No investigation I Director: A od in by the f 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00062172 M·D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHIARAD R SATYAL, MD 1604 MARKET ST. POCOMOKE CITY MD 21851. 32. Resistrar's Signature 31. Date filed (Month, State 2006 Registrar

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 2006 21 С. LILLY 1:15 pm 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Glen Burnie Anne Arundel 855 South Shore Drive If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax 8. Date of Birth (Month, Day, Year) 1 M 2 □ F Months Days Hours Yrs. 85 June 07, 1920 West Virginia 272-16-7238
Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 855 South Shore Drive 21060 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ØYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 I No Specify: Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Body & Fender Mechanic Auto Body Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lacy Lilly Marv Sovinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lacy C. Lilly (Son) 27084 Stafford Road, Marydel, Maryland 21649 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Lakeview Mem Park 05-25-06 Sykesville, Maryland 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A
3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Funeral/Service Licens an Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each limb. Immediate Cause (Final disease or condition remoned

Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours effer death.

To the Funerel Director: After this certificate has been signed by the attending native and Division of Vital Records, P.O. Box 68760. ours efter death. lerel Director: After this certific filled in by the funeral director,

**Physician** 

/Medical

Examiner

Direct

Funeral

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Completed

Be

2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other treumatic event, the Madical Exprintment must be incliffied at engine.

**Physician** /Medical

Baltimore, Maryland 21215-0036

with the Maryland

State

	resulting in death)	Due to (or as a consequ	tence of):	anaroma	of Stou	nach
miner	Esquentially list contaltions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.	Due to (or as a conseq		1	J	
dicai Exa	resulting in death) Last	Due to (or as a consequence	uence of):			
by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Bc. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of di 9 Unknown	1 death 3 □Ectopic	c pregnancy (specify)		23d. Date of delivery Month Day Year
ted by Pł	Part II. Other significant conditions conf	tributing to death but not res	ulting in the underlyin	gicause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
Completed	non	degrees	eny O	Anaenia	24a. Was an autopsy performed	
Be	25. Was case referres o medical examiner?				th (Check only one)	1/5-0-6-
2	1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	DOA Other: 4 Nursing H	ome 5 🗆 Residence	6 Dother (Specify) Hospice
	27. Mann of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
Medical Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specific	ome, farm, street, fac y)	tory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
edicai				red at the time, date and place, tion, in my opinion, death occur		e(s) and manner as stated. and place, and due to the cause(s)
Ž	29b. Signature and title of certifier	ceo	in	29c. License number	16 290.1	Date signed (Month, Day, Year)

7575 Ritchie Highway, Glen Burnie, Maryland 21061

DHMH 17 Rev 1/2001

Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Anil Chopra

31. Date filed (Month, Day, Year)

			For State Registrar	State of Maryland		artment of H			ene g. No.	06 16347
	Physicia	an l	Decedent's Name (First, Middle, Last)	,				2. Date of Death Month	Day	3. Time of Death
	/Medic	al		emaster		4b. City, Town, or	Leasting of Deat	May	2-0 ( 4c. County	2006 10:11 AM
	Examin	er	4a. Facility Name (If not institution, give s Larbor Lospit			Backti	more	n	N/X	7
	Funeral Director		5. Social Security Number 6. Sex 157-30-3546		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		924	9. Birthplace (State or Foreign Country) Germany
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mary a-f eh	tor	Maryland Anne Aru	ndel	Baltin	nore				1 ☐ Yes 2 No
	h with the 23s or 28	al Director	10e. Street and Number 614 Cresswel	l Road		10f. Zip Code	1225	10	g. Citizen of \	What Country?
36	perril. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptyglene. Importent: If item 27 le marked other then "naturel", or Items 23s or 28s-f ehow appring yor other treumatic event, it a Modical Examinational be notified at ange.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		e - American Indian, ck, White, etc.
8	2 hour	ted b	15. Decedent's Edu	cation	16a. Deced	dent's Usual Occupa	ation	1	6b. Kind of B	usiness/Industry
21215-0036	I within 72 lene. r then "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	rking	Food Service					
land	2 should be filed within and Menta! Hyglene. Ie marked other then eumatic event, It e M.	To Be C	17. Father's Name (First, Middle, Last)  Georg  J	ohann Riendl			18. Mother's Na Maria	me (First, Middle, M Mayer	aiden Suman	79)
Maryland	and 2 shou ealth and M n 27 le mar ser treumat	-	19a. Informant's Name/Relationship (Ty, Herman P. LeMaster					ural Route Number, 1 timore, i		State, Zip Code) 21225
Baltimore,	Pages 1 and nent of Health ent: If item 27 ury or other tr		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	metery, cren	sition (Name of matory or other place rematory				City or Town, State re, Maryland
Baltir	permil. Pag Department Importent: I any njury o		21. Signature of Funeral Service License		n 22	. Name and Addres	s of Facility	Funeral Hove., Balto		
	Fnysician /Medical Examiner	10	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	ne cause on each line.  Sepsis	Do not ente	er the mode of dyin	g, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death I Month  ease 2º Years I Month
8760,	cate be executed physician and s the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	l fa			1 Month		
P.O. Box 6	The law requires that the death certificate has been signed by the attending pt page 2 should be delached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deal 9 ☐ Unknown		1	23d. Date of delivery Month Day Year			
	uires that t signed by Id be detai	by	Part II. Other significant conditions con	ntributing to death but not result	ting in the ur	nderlying cause give	en in Part I.		acco use cont	ribute to the cause of death?
Division of Vital Records,	Physicien: The law requir this certificate has been si al director, page 2 should	Completed		24a. Was an autopsy perform	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?					
Vita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		t 3 DOA Othe	or	ath (Check only one		
on of	ding Phys	lon: To	1 Yes 2 No  27. Manner of Death  Natural 5 Pending  and Accident investigation		R/Outpatien 28b. Time of Injury	28c. Injury Work	4 🗆 (40) 3() ()	dome 5 ☐ Resider 28d. Describe hov		
Division	I or Attendiater death Director: A	Certificat	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str			28f. Location (Stre City or Town,	et and Numb State)	er or Rural Route Number,
_	To the Hospitel or Attending is within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical Co		sicien: To the best of my know ner: On the basis of examination and manner stated.	on and/or inv	vestigation, in my or	pinion, death occu	urred at the time, dat	te and place,	and due to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	U 2		29c. License	number	29	d. Date signed	d (Month, Day, Year)
)			Mi 5	H		RE	500	1	May	1 20 2006
	6		30. Name and address of person who co	mpleted cause of death (Item :	23a) (Type, Sout	Print) th Itan	nover	Street	Bu	Month, Day, Year)  1 20 2006  Altimore MD 2122
	Sta Registr		31' Date filed (Month, Day, Year)  MAY 2 4 2006	32. Registrar's Signatu	Ire Assa					2122

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 28f per meo 9858 8-10-06 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** MAY Binyam 18 2000 1900 Mulugeta /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Miller Gerys Cheverli 6 corge's S HOSP If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Min 1 XM 2 ☐ F 472-45-0952 23 Director 1983 Ethiopa Feb. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or itama 23a or 28a-1 ahow other traumatic avant, the Modical Examinar must be notified at 1 X Yes 2 No Director Dakota West Saint Paul 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1243 Oakdale Avenue 55118 Ethiopa Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Customer Service Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be to nent of Health and Mental Int: If Itam 27 is marked of Yoseph Mulugeta Delenesaw Siuda Mohammed 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Million Mulugeta - Brother 1243 Oakdale Ave., West Saint Paul, MN 55118 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Hillside Cemetery May 24,2006 Minneapolis, MN 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Albin Chapels 6855 Rowland, Eden Praire, MN 55344 meen lenne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a noneequence of or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician end for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 1 ☐ Yes 2 ☐ No by the 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe certificate 1 Yes 2 No 1 ☐ Yes Be 26. Place of Death Check only ne Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ this 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 3/0 Certification: After excited from vehicle 1. □ Natural 2 Accident 5 🗌 Pending 2006 .30 investigation 1 ☐ Yes 2 ☐ No the rollover Director 8 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Rt. 50 at Rt. 202 Landover, March 1985. 4 Homicide 5Theet within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical DO # HOUSS 927 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre Sylveston SHUANON 3001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Bleen De Apart

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 16349 Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2006 Louise Spiro Mitchell Mau 11:29am /Medical 4c. County of Death 4h City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Havre de Grace

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Harford Memorial Hospital Harford 9. Birthplace (State or Foreign Country)
New Jersey 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 80 07/15/1925 149-14-0814 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location rthen "natural", or Iteme 23a or 28a-f shov the Medical Examiner must be notified at WYes 2 No Directo MD Harkord Havre de Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 727 Warren Street 21078 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: δ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Supervisor of Medical Lab V.A. Hospital 4 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Spiro Antoinette LaFalse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent; if item 27 ie eny injury or other trau once. 727 Warren St., Havre de Grace, MD 21078 Gordon Mitchell- Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05/23/06 Aberdeen. MD 4 ☐ Donation 5 ☐ Other (Specify) Harf. Mem. Grdns. 21. Signature of Funeral Service Licensee 32 Name and Address of Facility Funeral Home, P.A. 30 Nov 123 S. Washington, Havre de Grace, MD 21078 23d. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) by Physician/Medical ed by the attending detached for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Year Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Latin 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ Mo After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No i Director: d in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funerel Di completely filled in 1 (Carrifyling Physician: To the best of my knowledge, death occurred at the time, that and place, and five to the revise(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Winau - mo 032609 5719186 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1106 Revalution St Havre De Grace MD 210'78 Metham ms amnidus 31. Date filed (Month, Day, Year) MAY 2 4 2006 32, Registrar's Signature State There is Registrar

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

2006 | 6350 Certificate of Death Reg. No Registra Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day May 20, 2006 LEE MARTIN 2147 hrs MICHAEL 4a Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Harbor Hospital Center Baltimore 5. Social Security Number If Under 1 Year If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 9, Birthplace (State or 6. Sex Age (In yrs. last birthday) Foreign Country) Maryland 220-72-8120 1 K M 2 F 43 Yrs 11,1963 Jan. Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Anne Arundel Brooklyn Park Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 619 Lorca Avenue U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, 1 Never Married 2 Married White, etc. Yes White 4 N Divorced If Yes, Give Year 1 Yes 2 / No specify: Specify. 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Compl 10 Carpenter Self-Employed 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Velma Larry Martin Jr. I. Hale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7673 Paradise Beach Road, Pasadena, Maryland 21122 Jeffery L. Martin (Son) 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition Date 20c. Location - City or Town, State Cedar Hill Cemetery 1 K Burial 2 Cremation 3 Removal from State 05-26-06 Baltimore, Maryland Donation 5 Other Specify Signature of Funeral Service Lice 22. Name and Address of Facility MgGullyFPolyniak Funeral Home, PMaryland 21230 art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Between Onset and Death Cardiomegaly Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last (1) X UNPENDED AMENDED item#23a,PII,27,perME,g856,6/1/06 TT ician/Mad 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death Month Dav Year 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Physi Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Fatty Liver 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of 52 performed? death? ✓ Yes 2 1 🗸 Yes 2 No 26. Place of Death (Check only one) 25 Was case referred to medical ្ល examiner? Other:
Nursing Home 5 Residence 6 Other: 1 V Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Injury 28d. Describe how injury occurred S 1 X Natural 1 Yes 2 No 5 Pending Hicafi 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) Homicid Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number O.C.M.E. May 21, 2006 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 a in 21. Date filed (Month, Day, Year) 32. Registrar's Signature

**ORIGINAL** 

P.0. Richard

The law requires that the death certificate be executed Attending Physician: death. ò To the Hospitel o within 24 hours aff To the Funeral Di

filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

DO051865

29d. Date signed (Month, Day, Year)

Costs Mile 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STATENES HOPATAL BALTIMORE CHARLES CURTIS

31. Date filed (Month, Day, Year)

MAY 2 4 2006



**DHMH 17 Rev 1/2001** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 2137 **Physician** Mause wayne ilbur 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA tospital Baltimore Union Memoria If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 220-36-099 100 M 20 F 65 07-02-1440 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at MiddleRiver 1 ☐ Yes 2 ☐ No Director Baltimore MD 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number death with 5 238 21220 Funeral 14. Race · American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours atter c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Itam any injury or other traumatic event, the Medical and once. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Smith TRUCK DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be relyn Mause harles ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Puecellville, VA Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 05/19/06 Battimore, MD Reenmount 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Per Funeral Syc 21. Signature of Funeral Service License Batto Next Pite, Battimore, MD 21939 con 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician arc IOMYOD /Medical Due to (or as a consequence off: Examiner atanary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ence of): Due to (or as a consi Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ò Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be deteched f Division of Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 No 1 TYes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide hours after within 24 hours a To the Funeral L 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

State

0

31. Date filed

Union

ed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

MI

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4 2006

2

MOORING, THEODORE

			1 - State Registrar	Certificate of Death	Reg. No.
	Physic	25	1. Decedent's Name (First, Middle, Last)	2. Date of Month	
	/Medi		THEODORE LOUIS MOORING, JR	NA'	Y 19 2006 10:21 AM
7	Examir	ner	4a. Facility Name (If not institution, give street and number)  SAINT AGNES HOSPITA		4c. County of Death
	Funeral Director		5. Social Security Number  2.5. QL. 1329  Usual Residence of Decedent  6. Sex  1 M 2 F  7. Age (In yrs.	Months Days Hours Min. (Month	of Birth h, Day, Year)  4 - 1965  9. Birthplace (State or Foreign Country)  MD
	yland			ty, Town or Location	10d. Inside City Limits
	with the Maryland a or 28a-f show Lbs notified at	rector	MD BALTIMORE GW	IYNN OAK 101. Zip Code	1 ☐ Yes 2 🗷 No
	after death with the Marylan or Items 23a or 28a-f show	Funeral Director	6511 GILMORE	21207	USA
21215-0036		by	11. Marital Status  12. Was Decedent Ever in U Armed Forces?  1 Yes, 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.)     1 □ Yes 2 № No Specify:	or No- 14. Race - American Indian, Black, White, etc.  Specify: BLACK
15-(	72	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
212	should be filed within and Mental Hygiene. marked other than imatic event, the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the	d Ho	Elementary/Secondary (0-12) College (1-4or 5+) 2 14 GRADE 2 YRS	GVMNASTIC COACH	GVMNASTIC
	e filec al Hyg othe	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mile	
<u>ylai</u>	Menti Menti arked	To E	THEODORE L. MOORING, SR.	RUTH LEWIS	
Maryland	2 sho	1	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route No.	
	1 and Healtl	1	XENOBIA MOORING (SISTER)  20a. Method of Disposition   20b. F	Place of Disposition (Name of Date	MIL MD 21244  20c. Location - City or Town, State
Baltimore,	permit. Pages 1 and Department of Health Important: If Itsm 27 sny injury or other tr once.		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	SEN MOUNT 05.22.06	
altii	permit. Pag Department Important: I sny injury o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility CREMATION SERVICE	BALTIMORE MD
00	Depa Impo sny ir		Vangha C J	5151 BAUTO, NATL' PIKE BAUT	10. Mo 21229
			23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	h. Do not enter the mode of dying, such as cardiac or respirato	ory arrest, Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  aACUTE  Due to (or as a conseq	ISCHEMIC BOWEL uence of):	Onset and Death 3 DAY 5
		ler	Sequentially list conditions but any, leading to immediate Due to (or as a consequence)	uence of):	
V	cuted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
60,	ertificate be executed ling physicien and e as the burial-transit	E EX	resulting in death) Last Due to (or as a conseq	uence of):	
68760,	physicate Is the t	Medicai	d		
O. Box	The law requires that the death certificate be executed to has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of do 9 □ Unknown	I death 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
<b>Q</b>	res that signed b	y Pi	Part II. Other significant conditions contributing to death but not rest	ulting in the underlying cause given in Part I. 23e. C	Did tobacco use contribute to the cause of death?
ord	w require been sig should b	Completed by	HIV	1	□ Yes 2 □ No 3 □ Probably 4 □ unknown
ecc	e lawr has be je 2 sh	npie	AIDS		Was an 24b. Were autopsy findings available prior to completion of cause of
of Vital Records,			END STAGE RENAL		performed? death?
×.	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2	26. Place of Death   Check or	
10	£ ⊊ ਜ਼	<u> -    </u>	27. Manner of Death 28a. Date of Injury	28b. Time of 28c. Injury at 28d. Descri	Residence 6 Other (Specify) ibe how injury occurred
sior	블로주호	atio	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury Work?  M 1 Yes 2 No	
Division	9 # 5 5	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factory, office 28f. Location City or	on (Street and Number or Rural Route Number, Town, State)
	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical (	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knot and manner stated.	wledge, death occurred at the time, date and place, and due to tion and/or investigation, in my opinion, death occurred at the time	the cause(s) and manner as stated. me, date and place, and due to the cause(s)
	To t withi To tl	Σ	29b. Signature and title of certifier	MP P12606	29d. Date signed (Month, Day, Year) MAY 19, 2006
			30. Name and address of person who completed cause of death (Item AJJAL ALVA, 900 CATON A	123a) (Type, Print) NVENUE, BALTIMORE,	MD 21229
	Sta Registr		31. Date filed (Mooth, Day, Year) 32 Registrar's Signa WAY 2 4 2006	ture	i

State of Maryland / Department of Health and Mental Hygiene ? For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5:40 PM 2006 Martin Jerome Mahon, Sr. May 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin Berlin Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 8, 1927 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 □ F Mary Yand Yrs. 220-20-1592 78 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MD Worcester Ocean City 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 2 why Injury or other traumatic event, the Medical Examiner must be an once. 21842 USA 9500 Coastal Highway #8G Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant State of Marvland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) M. Teresa King John J. Mahon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 112 E. Second Street; Frederick, MD 21701 Rev. M. Shawn Mahon son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Gardens 5/24/06 4 □ Donation 5 □ Other (Specify) Timonium, MD 21. Signature of Furtheral Service Licensee 1050 York Road 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Cers /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed ete hes been signed by the attending physician and page 2 should be deteched for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Onknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 201 this certificete 1 ☐ Yes 2 ☐ No 1 Yes within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Starting Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Manner of Death 28d. Describe how injury occurred Matural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Qay, Year) completed cause of death (Item 23a) (Type, Print) Constel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 5,20b per fh 9856 6-15-06 vt

State of Maryland / Department of Health and Mental Hygiene []

For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Carolyn 22, Manger May 2006 12:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore TOWSON

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Months Days Hours Min. (Month, Pay, Year)

DEC 14, 1916 210 Security Number 215-05-1039 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ **V**F 89 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No MD Baltimore Timonium Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 2525 Pot Spring Rd., Unit L 622 21093 U.S.A. iteme 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, permit. Pages 1 and 2 should be tiled within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Item eny Injury or other traumatic event, the Maritant and once. Black, White, etc. 1 ☐ Yes 2 ☐No If Yes, Give 1 Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bernard Ε. Haske Catherine С. Schaub ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deborah Carski-daughter 514 Hampton La., Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley 5<del>/2</del>/06 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Ull 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myrokk Myrowianic **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner or Attending Physicien: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physicien and 3 in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ X o 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No 1 🗌 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) &□\no npatient ဥ 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Ate of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2/Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funerel Completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person the completed caus and death (Item 23a) (Type, Print) ima 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

Manger, Caroly

06-03464 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 22, 2006 0154 hrs **Medical Examiner** MURPHY JAMES 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Maryland House of Corrections 8 Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Director 06/25/76 MARYLAND 29 218 86 0916 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 No 28a-f show LANDSDOWN BALTIMORE CO MD. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 2409 TIONESTA RD. APT. 21227 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married Yes Widowed If Yes, Give Year 1 Yes 2 XNo specify: Divorced Specify BLACK Examiner 2 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Mental Hygiene marked other than UNEMPLOYED N/A 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) ent of Health and Mental Hy nt: If item 27 is marked of r other tranmatic event, th Be JEANETTE LAREA ROBERTS JAMES EARL MURPHY. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 21212 SHERICE SHANKS(friend) Alhambra Avenue BALTO, MD. 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c Location - City or Town, State Date crematory or other place) 30 2 Cremation 3 portant: ury or oth  $\frac{26}{1000}$ , 2006 MT ZION CEM. BALTO, MD. Donation 5 Other Specify MAY ignature of Funeral Service Lice 22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME PRESTON ST. BALTO, MD. 41 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Multiple Sharp Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and ca X AMENDED UNPENDED 20b per fh g855 5-24-06 vt that the death certificate be Physician/Medi IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Yes 2 ✔ No 3 Probably 4 Unknown σ. Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? icate Yes 2 ~ the Hospital or Attending Physician: 26.Place of Death (Check only one) certif 25 Was case referred to medical of Vital æ examiner? Hospital: 1 Inpatient Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other Scene this ဥ 1 Yes 28a. Date of Injury FOUND: Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death Certification: Subject stabbed and cut **FOUND** Natural 1 Yes 2 V No Pending Director: May 22, 2006 0020 hrs 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined MD House of Corrections, Jessup, MD (Specify) Jail/Penal Fineral 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical ck only the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 1 Lo and manner stated 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E May 23, 2006

State

Registra

Laron Locke MD 31. Date filed (Month, Day, Year)

30. Name and address of person who

Assistant Medical Examiner Registrar's Signature

leted cause of death (Item 23a)



111 Penn Street, Baltimore, MD 21201

			For State Registrar	ate of Maryland / D	epartment of H			4000	16357
	Physici		1. Decedent's Name (First, Middle, Last)  1. Decedent's Name (First, Middle, Last)		48		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give stree  The Johns Hokun  5. Social Security Number  1. Sex  212–96 6814  Usual Residence of Decedent	t and number)  S OSPITA  7. Agl (In yrs. last birth	4b. City, Town, or Baltin	Location of Death  MOYE  If Under 24 Hrs.  Hours  Min.	May 3. Date of Birth (Month, Day, ) AUG. 21	4c. County of Deal N/A  (ear) 9. Bir Co. 1965 Mi	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or items 23a or 28a-f show any Injury or other treumatic event. The Medical Evaluate trust be recitified at ODGs.	To Be Completed by Funeral Director	10a. State 10b. County  MD . N/A  10e. Street and Number  2803 ASHLAND A  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educatio (Specify only highest grade continue) Elementary/Secondary (0-12) 12 TH  17. Father's Name (First, Middle, Last)  RALPH MAYO	VENUE Vas Decedent Ever in U.S. Immed Forces? Solve Yes, Give Year or Dates:  n Impleted) College (1-4or 5+) D	or Location  BALTIMORE  10f. Zip Code  21205  13. Was Decedent of Hill If Yes, specify Cuba  1 Yes 2 No  Decedent's Usual Occupa (Give kind of work done of the Do NOT use retired)  IETARY  Mailing Address (Street as	spanic Origin? (Spec n, Mexican, Puerto R Specify: ation during most of working ) 18. Mother's Name (	ify Yes or No- ican, etc.)  7  7  7  7  7  7  7  7  7  7  7  7  7	aiden Sumame)	orican Indian, e, etc. ACK (Industry PKINS HOSP
Baltimore, Mar	permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other treum		19a. Informant's Name/Relationship (Type, Informant's Name/Relationship (Type, Information 1 Surial 2 Cremation 3 Remote 4 Donation 5 Other (Specify)  21. Ignure of Funeral Service Licensee	R) 35 20b. Place of cemetery	38 Plmora Disposition (Name of , crematory or other place	ave. EAI Da  MAY 25 Sof Facility SCRUGGS	TO, MD. 2006 F 5 FUNER	21213 DC. Location - City or ANNE ARUI	
68760,	Medical Examiner and burial-transit	Ical Examiner	23a. Part1. Enter the disease, or complicatic shock, or heart failure. List only one call immediate Cause (Final disease) or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of	of enter the mode of dying the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the	g, such as cardiac or	respiratory arres		Approximate Interval Batween Onset and Death UNOVIS
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Division of Vital	Phye this al dii	Certification: To Be	2 Accident investigation	8a. Date of Injury 28b. T	ime of 28c. Injury Work	y at kt? Yes 2 □ No	e 5 Residen 8d. Describe how	ce 6 Other (Sperinjury occurred	
Ξ	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	ledical Cert	29a. Certifier 1 ☐ Certifying Physicia	in: To the best of my knowledge, On the basis of examination and and manner stated.			nd due to the cau	ise(s) and manner as	
	To the within To the Comp	Me	29b. Signature and title of certifier  101  30. Name and address of person who completes	Me DOC		- 000	290	d. Date signed (Mont.)	h, Day, Year) 1 2006 1 Howere
Di	Sta Regist	rar	Matthew. Baldwin 31. Date filed (Mooth, Day, Year) MAY 2 4 2006	1	ns Hospital,	600 North	Wolfe S	treet, one	aryland 21287

DHMH 17 Rev 1/2001

		ľ	For State Registrar	State of	Maryland		artmen tificate			and M		giene Reg. No.	2006	16358
7			1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		John Thomas	Oros							May	18	2006	
	Examin		4a. Facility Name (If not institution, g	ive street and num	nber)		4b. City,	Town, or	Location o	of Death		4c. C	ounty of Dea	ath
	3	N.	Anne Arundel Med					napol		2.11.			ne Aru	
	Funeral			Sex 1 M 2 □ F	7. Age (In yrs. last	birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da	y, Year)	0	rthplace (State or Foreign ountry)
1	Director		173-32-7671 Usual Residence of Decedent		65	115.					Oct.23	, 19	40 Pen	nsylvania
	and		10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City Limits
	Mary	io.	MD Anne A	rundel	Δn	napol	is							1 X Yes 2 □ No
	the redi	rec	10e. Street and Number	II dildo1	7111	пароз	10f. Zip	Code				10g. Citiz	en of What C	ountry?
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	death	Funeral Director	11. Marital Status		dent Ever in U.S.	13.	Vas Deced	lent of His	panic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	. 1.	4. Race - Am Black, Wh	erican Indian,
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	within sne. then	g L	Elementary/Secondary (0-12)	College (1-	-4or 5+)		ice (						shingt	
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yland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene the statusti, or Items 23s or 28s-f show Item 27 is marked other than "natural", or Items 20s or 28s-f show other traumatic event, the Medical Examinar must be notified at	To Be	John Edward (						Ma	ry Ar	nn Demo	ak		
ā	2 sho and is mu		19a. Informant's Name/Relationship	-		9b. Mailin	g Address	(Street a	nd Numbe		Route Numbe	-	Town, State,	Zip Code)
	and 2 lealth m 27 i		Catherine M. Oro	s/Wife			Lloyo sition (Nan		ırt,		apolis,		2140	
0	ges it of h		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3		State ceme	etery, cren	natory or o	ther place						r Town, State
Baltimore,	t. Pa rtmen rtent: njury		4 Donation 5 Other (Spec		West		ndel (				/2006		enton,	MD ome, P.A.
g	permit. Pages 1 and Department of Healti Importent: If Item 27 eny injury or other t		21. Signature of Funeral Service Lic	A/200	M01103	22					, Laur			707
			23a. Part1. Enter he disease, or co shock, or heart failure. List on	mplications that ca by onese on ea	aused the death. [ach line.	Do not ent	er the mod	e of dying	, such as	cardiac or	r respiratory ar	rest,		Approximate Interval Between
1	Physician	1	Immediate Cause (Final disease or condition		chemi		600		1					Onset and Death
	/Medical Examiner		resulting in death)	Dun to (	01.00.0.0000000000	on of):			1.					
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28	certificate nding phys use as the	edic												
XOR	w requires thet the death certifics been signed by the attending ph should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy							23	ld. Date of de	alivery
ň	death e atten	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 <u>□</u> Pregna	irth 2 ☐ Fetal de ant at time of death		]Ectopic pr ] Other (sp						Month	Day Year
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Υ	Th ete pag	ОП									perfo	rmed?	death? 1 ☐ Ye	
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0	Physicien: this certific al director,	၉	1 ☐ Yes No				t 3 DO		4 🗆 1901		ne 5 Resid	-		ecity)
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SIC	r Attending er death. rector: After by the funer	icat	2 Accident investigat 3 Suicide 6 Could not	be 200 Place	of Injury - At home	farm ctr	M (actor)		es 2 🗆 N		8f Location /9	Street and	Mumber or F	lural Route Number,
Division		Sertification:	4 Homicide determine		ng, etc. (Specify)	, 161111, 5111	eet, tactory	, onice			City or Tox	m, State)	rvarriber or r	iurar noute Number,
	Mospitel or 24 hours afte Funerel Directly filled in	edicai C	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the aminer: On the ba	best of my knowle	dge, death	occurred vestigation	at the time	e, date and	d place, a	nd due to the	cause(s) a	nd manner a	s stated.
	the hin 24	ledi	one)	and mann	er stated.									* *
	Vitl Con	Σ	29b. Signature and title of certifier	120			290	. License		10			signed (Mon	th, Day, Year)
	x \		- Light						3	10			110	
3	000		30. Name and address of person wh	Ole	e of death (Item 23		AA	M	2	2001	Medica	l Par	kway,	Annapolis, MD 21401
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 4 2006	32. Re	egistrar's Signatur	ade								
				4.										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			- State Registrar		Cei	rtificate of	Death		Reg	. No.	-			
			1. Decedent's Name (First, Middle, La	ist)				2. Date of	Death	Davi		3. Time of Death		
	Physici		John	James 0	'Hara, Jr.			Month	21.	2006	Year	8:40 P M		
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Dea			4c. County				
1	LAdiiii		Glen Meadows Car			Glen	Arm			Ra I	timo	20		
	Funeral				ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hi	s. 8. Date of	Birth					
	Funeral Director			1 <b>X</b> M 2□F	85 Yrs.	Months Days	Hours Mi	n. (Month,	Day, Y	ear) 1920		lace (State or Foreign try) / land		
			Usual Residence of Decedent		00			OCT.	25,	1920	riar	y I allu		
	land		10a. State 10b. County		10c. City, Town or Lo	cation					1	0d. Inside City Limits		
	f sh	ō	Maryland Baltimor	^e	Glen Ar	m						1 ☐ Yes 2 ☐ Wo		
	the P	ect	10e. Street and Number		41011 717	10f. Zip Code			100	. Citizen of V	Mhat Cour	tn/2		
	Aill or a	by Funeral Director							109			uy r		
	s 23	rai	11630 Glen Arm F		t 255	210					S.A.			
	ar de	un un	11. Marital Status	12. Was Decedent Armed Forces	?	Was Decedent of I If Yes, specify Cub	an, Mexican, Pue	orto Rican, etc.)	No-		e - Americ ck, White,			
36	s afte	уF	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 X Yes 2 If Yes, Give W Year or Dates:	N° TT	1 ☐ Yes 2 🌠 No	Specify:			Specify	<i>:</i>			
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show the Madical Examiner must be notified.	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during most of w	orking	16	b. Kind of Bu	usiness/Ind	dustry		
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	ed w ygie ygie t, th		<u> </u>	4	Pha	rmacist	T-1. T. T	<del></del>		Drug	5			
힏	d oth	Be	17. Father's Name (First, Middle, Last	*			18. Mother's Na	ame (First, Mid	dle, Ma	iden Surnam	10)			
<u>Ja</u>	Meni	ည	John J.	O'Hara, S	r.		Irene	Sc	ott					
Maryland	2 should be filled within or and Mental Hygiene. I a marked othar than "raumatic event, the Max		19a. Informant's Name/Relationship (	(Type, Print)	19b. Mailir	ng Address (Street	and Number or F	Rural Route Nui	mber, C	ity or Town,	State, Zip	Code)		
	alth 27 i		John J. O'Hara, 1	III Son	3 Mu	irfield	Court L	uthervi	11e	. Marv	land	21093		
5	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Itam 27 Is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Modical Exemples must be notified.		20a. Method of Disposition		20b. Place of Dispo			Date		c. Location -				
Baltimore,	permit. Pages 1 and 2 Department of Health at Important: If itam 27 la any injury or other trau once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special	□Removal from State fv)	Hilltop S			3-2006		Towson	. 1	Maryland		
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		-		gan		1050 Yor		Towson			u 212	Approximate		
н			shock, or heart failure. List only the caute on each line.											
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Immediate Cause (Final disease or condition)  a. Due to (or as a consequence of):  Due to (or as a consequence of):  b. Christian Due to (or as a consequence of):  Due to (or as a consequence of):											
1	/Medical Examiner													
н	Examiner		Sequentially list conditions	b. Chrome	ass vien	ve ful	minar	1 Chs	RAS	V		years		
	nik=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):		0				6			
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ŏ			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Dat	e of delive	ry		
m	ne death the atter thed for u	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a		]Ectopic pregnanc ] Other <i>(specify)</i> _	У			Mor	nth	Day Year		
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	The law requires that the death ate has been signed by the atter bage 2 should be detached for t		Part II. Other significant conditions	contributing to death b	out not resulting in the u	nderlying cause gr	ven in Part I,	23e. Di	d tobac	co use contr	ibute to th	e cause of death?		
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Division of Vital Records,	Phyaician: rthis certific ral director,	Be (	25. Was case referred to medical examiner?				26. Place of De	ath (Check on)	y one)			Mandid		
<b>}</b>	yaic is ce dire	To	1 Yes 2 No	Hospital: 1 Inpati	ent 2 ER/Outpatien	t 3 DOA Ott	ner: 4 Nursing	Home 5□Re	sidenç	e 6 tothe	er (Specify	Bushed		
0	g Ph er th seral		27. Manner of Death	28a. Date of Inju (Month, Da	28b. Time of Injury	28c. Inju	ry at	28d. Describ	e how i	njury occurr	ed	Civrag		
jo	Attanding F death. ctor: After y the funera	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		y rousy many		Yes 2 □ No					U		
/is	Atta r deg acto	ific	3 Suicide 6 Could not be determined	208. Place of in	jury - At home, farm, str	eet, factory, office		28f. Location	(Stree	t and Numbe	er or Rural	Route Number,		
D	afte Dire	Certification;	4 Homicide	building, e	c. (Specify)			City or	iown, S	tate)				
	spite		29a. Certifier 1 ☐ Certifying Pl	hysicien: To the best	of my knowledge, death	occurred at the ti	me, date and place	e, and due to the	ne caus	e(s) and mai	nner as sta	ated.		
	24 h 24 h Fur etely	Medical	(Check only 2 Medical Examone)	miner: On the basis of and manner st	f examination and/or in	estigation, in my	opinion, death occ	curred at the tim	e, date	and place, a	ind due to	the cause(s)		
	To the Hospital or Attanding Phyaician: The law within 24 hours after death. To the Funaral Diractor: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier	1 Aw		29c. Licens			29d.	Date signed	Month, E	Pay, Year)		
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Baltimore, Maryland 21215-0036	77	important: It item 27 is marked other than "natural", or items 23s of 26s-f show env injury or other traumatic event, the Medical Examinar must be notified at

	•	State Registrar				Cer	tificate	of I	Death	1		Reg. No	to O	UU	1 1		
	ė e	Decedent's Name (First, Midd	fle, Last)								2. Date of I	Death				ne of Death	
Physicia /Medica		Francis Cla									Month			2006	12	:20A M	
Examine	4a. Facility Name (If not institution, give street and number)  Saint Joseph Medical Center  4b. City, Town, or Location of Towns of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of							owso			Baltimore						
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D .	}	Usual Residence of Decedent  10a. State 10b. Count			10c. City, T	own or Lo	cation							T,	10d Incid	de City Limits	
Maryla B-f ehov	tor		, timore			vson	cation									Yes 2 No	
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and Men le marke aumatic	-	19a. Informant's Name/Refation	ship (Type, Print	1)							I Route Num						
m 27 In tre		Linda Alexan	der (Dau	ghter			Yello Sition (Name		cone		t, Ell					21042	
5°=5		20a. Method of Disposition  1 XBuriaf 2 ☐ Cremation  4 Donation 5 ☐ Other (	Specify)	from State	cem	etery, cren ey Va	lley N	dem.	. Gar	dens	26/06		Timo		, Ma	ryland	
permit. Pa Departmer important eny injury		21. Signature of Funeral Service		hen C	oster						ck Town				ome, 204	Inc.	
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	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of a continuous finite past 12 months?  1 □ Yes 2 □ No					2 Fetal death 3 Ectopic pregnancy					23d. Date of Month			delivery Day Year	
gned b	by PI	Part II. Dther significant condit		to death bu	t not resultin	ng in the ur	nderlying car	Jse give	en in Part l	l.	23e. Dio	d tobacco u	ise cont	ribute Io th	ne cause	of death?	
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nis certificate has b	Completed by	CONGESTIVE HEA									24a. Wa aut per	topsy rformed?		prior to coi death?	mpletion	ngs available of cause of	
or, pa	ပိ	MONOCYTIC MYEL  25. Was case referred to medic		ERATIV	E DIS	ORDER			ac Plan	o of Dooth	1 Yes			1 🗌 Yes	20 No		
this certifical director,	ToB	examiner?	4.4	1 Inpatien	1 2   FB	/Oulpatien	3 DOA	Othe	or		ne 5⊟Re		e □Oth	er (Specifi	14)		
ter t		27. Manner of Death 1 Natural 5 □ Pend	28a. l	Date of Injury (Month, Day	/ 28	b. Time of Injury		c. Injury Work		1	28d. Describe				y)		
after dea Director Jin by the	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of friury - At home, farm, street, factory, office building, etc. (Specify)								1	28f. Location City or T	(Street an	d Numb	er or Rura	l Route	Number,	
	Medical C	29a. Certifier (Check only one) Certify Medica	ing Physician: T	o the best of the basis of magner stat	examination	dge, death and/or inv	occurred arestigation, i	t the tim	ne, date ar pinion, dea	nd place, a ath occurre	and due to the	e cause(s) e, date and	and ma	anner as st and due to	tated.	ise(s)	
To th within To the compl	Me	29b. Signature and title of certific		m			29c.		number 7254			29d. Dat	te signe	d (Month,	Day, Yei	ar)	
0+1		30. Name and address of person 31. Date filed (Month, Day, Yea.					Print)			MARY	LAND	2120	714	t			

DHMH 17 Rev 1/2001

State

Registrar

MAY 2 4 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** RESC SIL EAN OR /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Year If Under 24 Hrs.
Days Hours Min. tea 1th Care 9. Birthplace (State or Foreign Country)
MARVLA ND 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 6. Sex Social Security Number Year) **Funeral** 1 ☐ M 2 🕰 F Yrs. 19-32-9082 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event. Its Mudical Examinar is ust be notified at 1⊠Yes 2 No MARYLAND Directo Citizen of What Country? 10e. Street and Number AVENUE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 2 🗷 No 1X Never Married 2 Married 1 Yes 200No Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) al Hygiene. College (1-4or 5+) COMMERCIALL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be find Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properties of Mental Properti JOSE PH ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 2105 LUNHURST AVE. BALTO, MD. 21216 Health tem 27 MOORE (GRANDDAUGHTER) ANTIA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1-06 MT. ZION CEMETERY 05 LANSDOWNE MARYLAND Important: any injury o `4 ☐ Donation 5 ☐ Other (Specify) ROWN JR. FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee JOSEPH H. K 2140 N. FULTON iamo BALTIHORE, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INFIARCTION Pnysician MYUCHRDIAL INKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by URONBEY ARTERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? LUNG 24a. Was an certificate has b irector, page 2 st autopsy performed? 1 ☐ Yes 2 ☐ No 2 🔲 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 22,2006 1005/865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SATTIMORE MI STACNES (HURLI25

DHMH 17 Rev 1/2001

State

Registrar

20463

CURTIS

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 19 Clara 2006 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Bayu, ew Johns Hopkin If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2/7/F Yrs Director 86 Maryland 217-05-9296 Sept. 26, 1919 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If Health and Mental Hygiene the Views 23a or 28e-1 show other traumatic event, the Miccial Exprime must be notified a 1 ☐ Yes ŽĮNo Director Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 802 Oakleigh Beach Road 21222 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specity: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Own Home Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othen by Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ William Mueller Louisa Memminger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 Oakleigh Beach Road Dundalk, Maryland 21222
Lice of Disposition (Name of Date 20c. Location - City or Town, State Rodger D. Pugh (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Star
4 Dopartion & Other (Coart ↑ □ Other (Specify) Oak Lawn Cemetery 05/24/2006 Baltimore, Maryland Funeral Seprice Licenses 22. Name and Address of Facility 21. Signature Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 Approximate Interval Between Onset and Death Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician 6 day intracerebral resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner signed by the attending physicien and dbe detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) ☐Yes 2 Mo 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 Yes 2 No 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 Minpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 3□ DQA ٩ 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. м 1 ☐ Yes 2 ☐ No 2 Accident ofter death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours effer To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Rolin K Wilm MD DOO 64461 5/19/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland, 21224 Robin Wilson, MD, 4940 Eastern Avenue, 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State MAY 2 4 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		Amend item#16b,perl  1 - State Registrar	H, 9855, 5/2 State of	Marylan	d / Depa <i>Cei</i>	artment of tificate of	Health Death	and M	lental Hy	ygiene Reg. No		16363
Physici	ian	1. Decedent's Name (First, Middle, La Rosie V. Parke							2 Date of D Month	eath Day	ماطور -	3. Time of Death
/Medio		4a. Facility Name (If not institution, given		per)		4b. City, Town,	or Location	of Death	MAC	4c.	County of Death	1 = . = 07,
EXAMI		Baltimore Washi			1 Cen		Glen		nie	P	nne Arı	ındel
Funeral Director	Г		6ex 7.	Age (In yrs. I	ast birthday) 60 Yrs.	If Under 1 Yea Months Day		24 Hrs. Min.	8. Date of B (Month, D July	irth 3ay, Year) 30 1	9. Birthp Cour 945 Ma	elace (State or Foreign etry) aryland
Alpha V		Usual Residence of Decedent							1 1			
arylan show	51	10a. State 10b. County	runde1		,Town or Lo napol						1	0d. Inside City Limits 1 □ Yes 2 □ No
the M	ecto	faryland Anne A			Tapoz	10f. Zip Code				10g. Cit	izen of What Cour	**
with with	ā	804 Betsy Ct.	Apt A			214					ISA	, .
death ms 2	Funerai	11. Marital Status	12. Was Deced		S. 13.	Was Decedent of f Yes, specify Cu		igin? (Sp	ecify Yes or N		14. Race - Americ	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28a-f show apprigning or other traumatic avent, Ite Medical Exercities matter incilling at ance.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Force 1 □Yes 2 If Yes, Give Year or Date	<b>X</b> No		1 □ Yes XXN			Hican, etc.)		Specify: B1a	
72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give	dent's Usual Occi	e durina mos	st of work	ing	1 -	ind of Business/Inc	es
within no.	mpi	Elementary/Secondary (0-12)	College (1-4	lor 5+)		DO NOT use retir		L			ted <del>Sta</del>	tes-
Hygie Hygie ther t		12th 17. Father's Name (First, Middle, Lasi	0		Tab	le Atte			e (First, Middle		al Acad	lemy
2 should be filed within and Mental Hygiene. Is marked other then aumatic event, ILAM	To Be	William Dorsey					Ros	sie	Parke	r		
ary ica	-	19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	ng Address (Stree	et and Numb	er or Run	al Route Numi	ber, City o	r Town, State, Zip	Code)
Tand 2 Health a		Rhonda Parker(	Daughte				t. A			T	is, Md.	
Pages 1 nent of Hant: If Iter		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 [	Removal from St	ato Co	emetery, crer	sition (Name of natory or other p			Date		ocation - City or To	
permit. Pages Department of Important: If It any injury or o		4 □Donation 5 □ Other (Special Signature of Funeral Service Lice		St		t Cemet	_			1	over, M	[d.
permit. Departr Importa		21. Signature of Funeral Service Lice	nsee Mod	483	Wi	Name and Add	se & S	Sons	Mort	uary	P.A.	. 1
		23a. Part1. Enter the disease, or con	plications that cau	sed the death							d. 2140	Approximate
Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on eac	in line.	14		inde					Interval Between Onset and Death
/Medical		resulting in death)	a. Due to (or	as a consequ	Jence of):	-	- Cury	,				
Examiner	L	Sequentially list conditions, if any, leading to immediate	bV&	sulan	- ls	ne S	epon	2				ř.
bed is	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (of	as a consequ	Jence of):	1 1:1						· Yes
execunand nand ial-tra	Exar	that initiated events resulting in death) Last	C. Due to (or	as a consequ	uence of):	in June	~E					251
cate be executed physician and the burial-transit	dical	(	d. ath	eros 0	deros	18						
entifica ding pt	Med	IF FEMALE:						,				
w requires that the death certific been signed by the attending fahould be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		ome of pregna h 2 □ Fetal nt at time of de	death 3	Ectopic pregnan Other (specify)	су				23d. Date of delive Month	ny Day Year
the dy the ached	ysk	1 □ Yes 2 No 9 □ Unknown	9□Unknow		Juli 5 L	- Cities (Specify)						
s that	by P	Part II. Other significant conditions	contributing to dea	th but not resu	ulting in the u	nderlying cause g	oven in Part	1.	23e. Did	tobacco u	ise contribute to th	e cause of death?
equire ean sig									10	Yes 2	□No 3□Prob	ably 4 Unknown
law ras be	Completed								24a. Wa auto	ODSV	prior to cor	psy findings available inpletion of cause of
The									perf 1 ☐ Yes	formed? 20 No	death?	2 \( \text{No} \)
sician: The law scertificate has b irector, page 2 si	o Be	25. Was case referred to medical examiner?	Hospital:				ther		h (Check only			
Phys ar this aral di	-	1 Yes 2 No 27. Manner of Death	28a. Date of	Injury	ER/Outpatier 28b. Time of	28c. Inj	ury at		me 5 Res 28d. Describe		6 □Other (Specify y occurred	"
ath. rr: Afte	atio	1 Natural 5 Pending 2 Accident investigation		Day Year)	Injury		ork? ∐Yes 2 ∐	No				
or Atter de lirecto	Certification;	3 ☐ Suicide 6 ☐ Could not to determined	289. Place 0	f Injury - At ho , etc. (Specify	me, farm, str	eet, factory, office	3			(Street an own, State	d Number or Rura )	l Route Number,
pital Durs a Gilled	_	29a. Certifier 1 Certifying P	nysician: To the b	est of my know	wledge death	a occurred at the	time date a	esela be	and due to the	2 (21150/5)	and manner as st	atad
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	Medical	(Check only 2 Medical Exa	miner: On the bas and manne	is of examinat	tion and/or in	vestigation, in my	opinion, dea	ath occurr	ed at the time	, date and	place, and due to	the cause(s)
To To	2	29b. Signature and title of certifier				29c. Licei	nse number	-7		29d. Dat	e signed (Month, i	Day, Year)
~		CANAL TO THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY	My	-1	00-1 00	<u> </u>	1391			nou	17 2	DVO
2		30. Name and address of person who	completed cause	1 . 44	23a) (Type,	Colors &	lara de	1	ms.	2 m	61.	
	ate	31. Date filed (Month, Day, Year)	32. A	istrar's Signa	-	Jun 2	VF /~/~			- 10	۸۱.	

Registrar

DHMH 17 Rev 1/2001

			For State Registrated Item	State of M	larylan	d / Depa	artment	of H	ealth a	and M			006	16364
·	Physicia	1.0	1. Decedent's Name (First, Middle Hazel	1 #1/ Per I'H e, Last)	- <del>6855</del> -	<del>5/24/</del>	U5 JH	Rav			2. Date of Dea Month		Year 2006	3. Time of Death 8:12a • M
	/Medic Examin	-	4a. Facility Name (If not institution	n, give street and number	)		4b. City,		Location of	of Death	1		unty of Death	)
			654 Alpine	Lane					inst	er			Carr	oll
	Funeral Director		5. Social Security Number 249-07-1942	6. Sex 7. A	ge (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 02 13	th y, Year) 3 <b>1</b> 8	9. Birth	place (State or Foreign Intry) SC
	pu *		Usual Residence of Decedent  10a, State 10b, County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	lanyla et at	ō		roll		West		or						1 ☐ Yes 2 No
	28a-i	Funeral Director	MD Car	LOIT		West	10f. Zip					10g. Citizer	of What Cou	untry?
	3a or		654 <b>\1</b> -i T					211	57			71	S.A.	
	me 2	nera	654 Alpine I	12. Was Deceden Armed Forces	t Ever in U.	S. 13.	Was Deced			gin? (Sp	ecify Yes or No Rican, etc.)		Race - Amer Black, White	
9	after or Ite	Fu	1 Never Married 2 Mar	ned 1 □Yes 2 <b>X</b>			1 □ Yes				ricari, etc.,			
21215-0036	within 72 hours after death with the Maryland ene. than "natural; or Iteme 23a or 28a-f ehow tha Madical Examir ar mual be motified at	d by	3X Widowed 4 □ Divorced	Year or Dates	:									lack
15-	"nati	Completed	(Specify only highe	nt's Education st grade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	k done d	during mos	t of work	ing	16b. Kind	of Business/I	ndustry
7	within ene. than	E C	12th grade	College (1-40)	r 5+)		Tead		•			Balt	imore	City
	illed Hygi other	Be C	17. Father's Name (First, Middle,	Last)		L	**		18. Mothe	er's Nam	e (First, Middle,	Maiden Su	mame)	
lan	should be filed with nd Mental Hygiene. I marked other that umatic event, the h		George W. Gr	ham amham					Emr	na M	louzon			
Maryland	01 02 02 02		19a. Informant's Name/Relations				-				al Route Numbe			
	1 and Health em 27 thar tr		Regina Prior-	-Daughter	20h P	654			Lane		lestmir		, Md	21157
Baltimore,	Pages 1 nent of 1- int: If Ite iry or ot	İ	20a. Method of Disposition  1 Burial 2 Cremation 4 Donation 5 Other (S	3 Removal from Stat		emetery, crei	natory or o	ther place	1					
Ē			4 Donation 5 Other (S	The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon	Met	tro C	remat	d Addres	7 Inc	5.5	/24/06	Bal	timor	e, Md
Ba	permit. Departr Imports any inj		Cola	marc	4	4		Vaba	ash <i>l</i>	Ave,	Balti		, Md	21215
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that cause t only one cause on each	ed the death line.	n. Do not ent	er the mod	e ol dying	g, such as	cardiac	or respiratory ar	rrest,		Approximate Interval Between Onset and Death
2	Physician		Immediate Cause (Final disease or condition resulting in death)	_a	rek	2920	Vas	cn	IN	F	tead	ent		Oliset and Death
	/Medical Examiner		resulting an death)	Due to (or a	s a consequ	uence of):	2							
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	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1. 00	NSi	no	cho	or	der					
oʻ	le be executed ysicien and e burial-transit	Еха	resulting in death) Last	Due to (or a	s a consequ	uence of):				1				
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89	artifica ing pt a as tl	Physician/Med	IF FEMALE:											
Box	ath ce ttendi	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Feta	Ideath 3	Ectopic pr					230	. Date of deline Month	very Day Year
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□ Unknown		eath 5L	Other (sp	ecity)						•
P.0	that the ed by detac	/ Ph	Part II. Other significant conditi	ons contributing to death	but not rest	ulting in the u	nderlying c	ause give	en in Part I		23e. Did to	obacco use	contribute to	the cause of death?
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ita	rtifica	BeC	25. Was case referred to medica	al					26. Place	of Deat	h (Check only o			
) L	Physic this ce	ToE	examiner? 1 □ Yes 2 X No	Hospital: 1 🗌 Inpa	tient 2 🗆	ER/Outpatie			4 🗆 140	ursing Ho	me 5 Resid	dence 6	Other (Spec	ify)
u o	Attending Physician: It death. ector: After this certification in the funeral director.	ou:	27. Manner of Death 1. Natural 5 □ Pendi	28a. Date of In (Month, D	jury Day Year)	28b. Time o Injury		8c. Injury Work			28d. Describe I	now injury o	ccurred	
Sio	ttend death ttor: /	cati	3 Suicide 6 Could		niunz - At ho	omo form et	M laston		Yes 2	No	281. Location (S	Street and N	lumber or Ru	ral Route Number,
Division of	after of Direction by	Certification:	4 ☐ Homicide deter	nined 286. Place of 1 building,	etc. (Specif	y)	eet, ractory	, once			City or Tox	vn, State)	BINDER OF FIB	ar noble vertiber,
_	Hospital or 24 hours afte Funerel Dir tely filled in	alc	29a. Certifier Certifyi	ng Physician: To the be	st of my kno	wledge, deat	h occurred	at the tin	ne, date ar	nd place,	and due to the	cause(s) an	d manner as	stated.
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2:	Medical	(Check only 2 Medica one)	Examiner: On the basis and manner	of examina	tion and/or in	vestigation	, in my o	pinion, dea	ith occur	red at the time,	date and pla	ace, and due	to the cause(s)
	within To th	Σ	29b. Signature and title of certific	er 2NO			290		e number	br			igned (Month	1
	-1		> Cofun	NINNA			~	ח ה	517	レラ		5-	15-0	D
	7		30. Name and address of person	77 349	Nor	(WIM	Print	)	We	ntm	instaz	- 1	no 2	1157
Sec. of	Sta Registi		31. Date filed (Month, Day, Year MAY 2 4	2006 <b>3</b> 2. Regis	strar's Signa	ature	AL S							

	1 = For State Registrar	State of Maryland / De	epartment of Hea Certificate of De	eath	ıı mygie Reg.		1636
	1. Decedent's Name (First, Middle, Las	t)		2. Dat Mo	e of Death	Day Year	3. Time of Death
ician dical	Sam	Sti	reater			Day Year	12:30 A ^N
niner	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Lo			4c. County of Dea	
	Southern Maryland	l Hospital	Clinton	n		Prince G	eorge's
al	Social Security Number     6. Se	MA OFF	Months Days F	Hours Min /A/o	e of Birth	9. Bin	thplace (State or Foreignuntry)
or	250-98-6356 Usual Residence of Decedent	52 Yrs		Jun	ie 9,	1953   Sou	th Carolin
	10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limit
ŏ	Maryland Prince G	George's Forestvi	110				1 X Yes 2 ☐ N
To Be Completed by Funeral Director	10e. Street and Number	eorge a Toresevi	10f. Zip Code		10g.	Citizen of What Co	ountry?
	3413 Princess Grac	e Court	20747			S.A.	
ner	11. Marital Status		13. Was Decedent of Hispa If Yes, specify Cuban, M	anic Origin? (Specify Ye		14. Race - Ame	
F	1 ☐ Never Married 2 🔀 Married	Armed Forces?  1 XYes 2 No 1972  If Yes, Give			etc.)	Black, Whit	e, etc.
by by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 1992	1 ☐ Yes 2 🛣 No S	ipecity:		Specify: B1	ack
Completed	15. Decedent's Ed (Specify only highest grad	ucation 16a. De	ecedent's Usual Occupation	n na most of warking	16b	. Kind of Business	Industry
l du	Elementary/Secondary (0-12)	College (1-4or 5+)	ive kind of work done durir e. DO NOT use retired)				
ြင်	12	Se	curity Guard			curity	
a	17. Father's Name (First, Middle, Last)		18.	. Mother's Name (First,	Middle, Maid	den Sumame)	
ိုင				Lydia Jane			
	19a. Informant's Name/Relationship (7) Carolyn Streater		ailing Address (Street and				
	Ú		3 Princess G				
	20a. Method of Disposition 1   Burial 2 □ Cremation 3 □	Removal from State	sposition (Name of crematory or other place)	Date	20c.	. Location - City or	Town, State
	4 □Donation 5 □ Other (Specify		e Nat. Cemet			lorence,	
	21. Signature of Funeral Service Licens	900	22. Name and Address of Grooms Fune 1071 Highwa	f Facility			
	Dennes Ti	Mnew	1071 Highwa	y #1 South,	, Cher	aw, SC 29	9520
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. Do not one cause on each line.	enter the mode of dying, so	uch as cardiac or respira	atory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	. End stasm Co.	asestin hear	at failur			Onset and Death
	resulting in death)	a. End Stage Co.  Due to (or as a consequence of):					75-764 65 2
	Sequentially list conditions.	Due to (or as a consequence of	outh				- 4
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of:					
Kam	that initiated events resulting in death) Last	C					
		Due to (or as a consequence of):					
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₩.	IF FEMALE:	20- 16					
an	23b. Was decedent pregnant in the past 12 months?		3 Ectopic pregnancy			23d. Date of deli	very Day Year
ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)			171011111	Juy I bai
by Physician/Med	Part II. Other significant conditions co	ntributing to death but not resulting in the	a underlying cause anno !-	Part I	Did tobara	O USO contribute	the cause of death?
	3	zg to seath but not resulting III (III	o underlying cause given in	236			the cause of death?  bably 4 20 Unknow
etec					1 1 1 1 1 1 1	2 NO 3 PR	
Completed				24a	. Was an autopsy	prior to c	topsy findings available completion of cause of
S				10	performed? Yes 2 €	?   death?	2 🔀 No
0	25. Was case referred to medical examiner?			. Place of Death  Check			
00	1 195 2 BENO	Hospital: 1 Manpatient 2 ☐ ER/Outpa		Nursing Home 5	Residence	6 Other (Spec	rify)
မ	27. Manner of Death	28a. Date of Injury 28b. Time (Month, Day Year) Injur		28d. Des	scribe how in	jury occurred	
မ	1 Natural 5 Pending		M 1 TYes	2 🗆 No			
2	2 Accident investigation		street factory office	28f. Loca City	ation (Street or Town, Sta	and Number or Ru	ral Route Number,
2		28e. Place of Injury - At home, farm, building, etc. (Specify)	street, ractory, office				
Certification; To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)					
Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined  29a. Certifier 1 Cartifying Phy (Check only 2 Madical Exami	building, etc. (Specify)  sician: To the best of my knowledge, de ner: On the basis of examination and/or	eath occurred at the time. d	ate and place, and due	to the cause	(s) and manner as	stated.
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Certification; To	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	sician: To the best of my knowledge, dener: On the basis of examination and/or and manner stated.  M. D  completed cause of death (Item 23a) (Type	path occurred at the time, d investigation, in my opinio	late and place, and due in, death occurred at the imber	time, date a	Date signed (Month	to the cause(s)

State of Maryland / Department of Health and Mental Hygiene 1 6 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Wayne Lee Stull Мау 2006 10:05P 17 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 16, 1936 5. Social Security Number 214-34-1138 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F 69 Mary land Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at Frederick 1 Yes 2 No Maryland Frederick Funeral Director 10e. Street and Number 8III Runnymeade Drive 10g. Citizen of What Country? 10f. Zip Code ò 21702 U.S.A. or Items 23e filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: ρ 3 Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) Coflege (1-4or 5+) Processor Dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth eny injury or other traumatic event ans. Zella Younkins Noble Stull Sr. 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara L. Stull/Wife 8111 Runnymeade Drive, Frederick, MD 21702 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Mount Olivet Cemetery 1 Burial 2 □ Cremation 3 □ Removal from State May 20, 2006 Frederick, MD 4 □ Donation 5 □ Other (Specify) 21. Signatur Funeral Service Licensee 22. Name and Address of Facility
Keeney and Basford Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21701 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ACMITE PULMONARY EDEMA /Medical Due to (or as a consequence of): Examiner INFARCTION 18 URS MYOCARDIAL A CUTE Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ EMPHYSEM4 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has performed? (es 2)2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After a funeral Director of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit of the funeral bit 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 016675 Own 30. Name and address of person who comple use of death (ftem 23a) (Type JKYNG TUGHER 32. Registrar's Signature 31. Date liled (Month, Day, Year) State MAY 2 4 2006 Registrar

	1	For State Registrar	State of M		id / Depa		t of H	ealth a		ental Hy			16367
Physician /Medical Examiner		I. Decedent's Name (First, Middle, Landson Markers)  a. Facility Name (If not institution, given the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second	DEVET	, 3	She	4b. City,	Town, or	Location o	-11	2. Date of De Month	16 Day	2006 County of Dear	3. Time of Death 2:45A M
Funeral Director		5. Social Security Number 218-07-6801			last birthday) 89 Yrs.	If Under Months		If Under 2 Hours		8. Date of Bir 1/1/1, 24	*1 <b>91</b> 6	9. Birt	hplace (State or Foreign buntry)
Maryland a-f show		Jsual Residence of Decedent  10a. State 10b. County  MD Baltimo	re		ty, Town or Lo								10d. Inside City Limits 1 □ Yes ※XNo
15-0036  n 72 hours after death with the Maryland n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show bottol Examiner must be notified at		10e. Street and Number  709 Maiden Choi 11. Marital Status	12. Was Decedent	Ever in U	I.S. 13. V		21228		gin? (Spe		Unite	zen of What Co ed Stat nerica 14. Race - Ame	es arican Indian,
nours after d real; or item Learning	5	1 ☐ Never Married 2 ☐ Married  XX Widowed 4 ☐ Divorced	Armed Forces  1  Yes 24  If Yes, Give  Year or Dates:	? No		1□Yes 】	XX No	Specify:	, Puerto f	Rican, etc.)			nite
n 72 n and a second	and in	15. Decedent's E (Specify only highest given the secondary (0-12) 12th		5+)	16a. Deced (Give life. I Homes	kind of wor DO NOT us	al Occupa rk done d se retired)	tion uring most	of workir	ng		nd of Business Home	rindustry
aryland 212: should be filed within and Mental Hygiene. marked other than umaits event, the To Be Comp.	2	17. Father's Name (First, Middle, Las Jonathan Moxley	Elkridge					Mari	e An	(First, Middle ne Ward	đ		
	-	19a. Informant's Name/Relationship  Suzanne S. Dillm  20a. Method of Disposition		20b. i	3410	Bix1	er Cl	nurch	Roa	d; We	stmin	Town, State, Inster, Inster, Inster, Inster, Inster, Insternation - City or	MD 21157
Baltimore, permit. Pages 1 a Department of Hee Importent: if tem any injury or othe	-	1  Burial 2  Cremation 3  4  Donation	ify)	Lo	rraine 22	Park 2. Name an	Ceme	tery s of Facilit	y Lou	don •Pa	ark F	uneral	
<b>o</b> §§§§§		23a. Part Enter the disease, or corshoek, or heart failure. List only	y one cause on each	line.	th. Do not ent	ter the mod	e of dying	, such as				, MD 2	1229 Approximate Interval Between Onset and Death
Pnysician /Medical Examiner		Immédiáte Cause (Final disease or condition resulting in death)	Due to (or a	s a consec		ma	10.	>15					
8760, Carle be executed by sician and the burial-transit direct Examiner	ימו דיאמ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a										
Vision of Vital Records, P.O. Box 68 Attending Physicien: The law requires that the death certificat in death. Sector: Atter this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the idication: To Be Completed by Physician Madil	Iyaiciai limed	IF FEMALE: 23b. Was decedent pregnant in the past 12,months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	aldeath 3	⊒Ectopic pr ⊒ Other (sp					2	23d. Date of de Month	livery Day Year
cords, P wrequires that been signed b should be deta		Part II. Other significant conditions	contributing to death	but not res	sulting in the u	inderlying c	ause give	on in Part I.					o the cause of death?
Division of Vital Records, to Attending Physicien: The taw requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be partitive to the Completed by	non bier							_				24b. Were as prior to death?	utopsy findings available completion of cause of
Vital F sicien: The certificate irector, page	מ	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ NO	Hospital: 1 ☐ Inpat	tiont 2	ER/Outpaties	nt 3 DC	Othe		/	(Check only		S □Other (Spe	- vifu)
ion of Value of Physicath.  r: After this continue funeral director.		27. Manner of Death  1 Natural 5 Pending 2 Accident investigati	28a. Date of In (Month, D	jury	28b. Time o		28c. Injury Work			28d. Describe			0.17)
Divinities or ris after all Diri		3 ☐ Suicide 6 ☐ Could not determine	building,	etc.*(Speci	ify)					City or To	wn, State	)	ural Route Number,
the Hospi thin 24 hour the Funer impletely fil	alcal	29a. Certifier 1 Certifying F (Check only one) 2 Medicel Ex-	Physicien: To the bes aminer: On the basis and manner:	of examin	owledge, deat ation and/or in	h occurred ivestigation	at the time, in my of	ne, date an pinion, dea	id place, a th occurr	and due to the ed at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
To the within To the compli	3	29b. Signature and title of certifier	7			290	c. License	number				e signed (Mont	
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C		30. Name and address of person wh  31. Date filed (Month, Day, Year)	one, T	death (Ite	Maide	nC	Lho	ice	La	ne,	Bal	timore	2006 2,MD21228
State Registra			106	20 0	ature	1							

			For	Please						ealth and N	•		_	Die.	
			1 - State Registrar				Ce	rtificate	of L	Death		Reg. N	20	06	16368
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	/Medi Exami		4a. Facility Name (If n	ot institution, give	street and number	er)		4b. City, To	wn, or	Location of Death		40	c. County	of Death	
			BALTIMUR	= VAM	edical	CENT	ter	1	BA1	HimoRe			N/	4	
	Funeral Director		5. Social Security Nun 232-26-38		x 7 XM 2 ☐ F	Age (In yrs. 81	last birthday) Yrs.		Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Sept.	av Year	1924	9. Birthpla Counti West	ace (State or Foreign ry) Virginia
	pu .		Usual Residence of D	ecedent 0b. County		100 Cit	y, Town or Lo	ostica						110	d Inside City Limits
	ehov	5		_										10	d. Inside City Limits 1 XYes 2 No
	the M	ect	WV 10e, Street and Numb	Grant		Pet	ersbui	10f. Zip Co	vde.			10a C	itizen of N	What Countr	
	with Sa or	ā	106 Moun		w Street				847	7			.S.A		
	me 2:	Funeral Director	11. Marital Status		12. Was Decede		.S. 13.			spanic Origin? (Sp n, Mexican, Puerto	ecity Yes or N		14. Rac	e - America	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Mydical Examinar must be civilled at	À	1 ☐ Never Married 3 🕅 Widowed 4		Armed Force 1 📉 Yes 2 [ If Yes, Give Year or Date	_N ₀ 194	)	liYes, specify 1 □ Yes 2【		n, Mexican, Puerto Specify:	Rican, etc.)		Blac Specify	ck, White, e V: Whit	
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	2 should be filed v and Mental Hygie is marked other t raumatic event, III		17. Father's Name (Fi	rst Middle Last)			Inst	rance	Age	18. Mother's Nam	e (First Middle	<u> </u>			rity Ins.C
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Maryland	Shoul nd Me mark	2	19a. Informant's Nam		,	thter)	19b. Maili	ng Address (S	treet a	and Number or Run				State, Zip C	Code)
	nd 2 stith at 27 is r trau		Teresa F			giitel		Box 26		Maysvill					,
ē,	f Heal item 2		20a. Method of Dispo	sition		20b. F	lace of Dispo	sition (Name			Date			City or Tow	m, State
E	Pages nent of unt: if it		1 LX Burial 2 ⊔ 4 □ Donation 5		Removal from Sta			lle Ce			3/06	Lahı	nansv	ville,	WV
Baltimore,	permit. Pages 1 and 2 s Department of Health at important: if item 27 is any injury or other trau <u>once</u> .		21. Signature of Fune	ral Service Licen	See )	ile	22	Name and A chaeff 1 N. M	er ain	s of Facility s Funera s St., Pe	1 Home	· o T	JV 26	5847	
	Physician /Medical Examiner		23a. Part 1. Enter the shock, or heart! Immediate Cause (Fi disease or condition resulting in death)	nal	a. GAST Due to (or	ROIN as a conseq	TESTI) uence of):	VAL 1	HE	g, such as cardiac  MORRHA  LONS OF	GE		- TT 2	(	Approximate Interval Between Onset and Death
68760, 🥢	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in, that initiated events resulting in death) La.	itions, ediate ediate ing ury st	Due to (or	as a conseq	uence of):								
P.O. Box 6	that the death certificate ed by the attending phy detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent p in the past 12 m 1  Yes 2 1 9 Unknown	onths?	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	Ideath 3[	Ectopic pregr Other (specia					23d. Dat Mor	e of delivery	y Day Year
<u>ر.</u>	uires that signed b d be deta		Part II. Other significa	ant conditions co	entributing to death	but not res	ulting in the u	nderlying caus	se give	n in Part I.	23e. Did	tobacco	use contr	ribute to the	cause of death?
of Vital Records,	w require been sig should b	Completed by	ASPIRAT	ION OF	GASTRIC	CON	TENTS				1 🗆	Yes 2	□No	3 🗌 Probab	bly 4 Unknown
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Ž	hysic his co	2	1 ☐ Yes 2 No	>	Hospital: 1 💢 npa	itient 2 🗆	ER/Outpatier		Othe	4 Littlishing 110	me 5□Resi	dence	6 🗆 Othe	er (Specify)	
Division o	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide	5 Pending investigation 6 Could not be determined	28e. Place of	Day Year)	28b. Time of Injury	М		fes 2 □No	28f. Location ( City or To	Street a	nd Numbi		Route Number,
D	Hospital c 14 hours af Funeral Di 16ly filled in		(Check only 2	Certifying Phy	/sician: To the be iner: On the basis	st of my kno	wledge, deati	n occurred at t	he tim	e, date and place, inion, death occurr	and due to the	cause(s	) and ma	nner as stat	red. he cause(s)
	thin 2 the mplet	Medical	one) 29b. Signature and tit		and manner	stated.				number				l (Month, Da	•
	J. W. D. O.		Day:	775	MP		٠			435T1580	3		19/2	,	1, rear)
	4		30. Name and addres			f death (Item	23a) (Type,	Print)	Ne	Street	BALT	nur.	e. M	دار (	2e /
	Sta Begist	ate	31. Date filed (Month,	Day, Year)	32 Regi	strar's Signa		20 .							

			State of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hygie	ne2 0 0 6	16369
e z	Physici /Medic		Decedent's Name (First, Middle, Last)     VERGIE LEE THOMPSON		2. Date of Death Month MAY 1	Day Year 7 2006	3. Time of Death  2:50 P
	Examir		4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL	4b. City, Town, or Location of Death		4c. County of Death	
· 被	Funeral Director		5. Social Security Number 6. Sex 1 M 2 K F 7. Age (In yrs. last birthday 88 Yrs.	y If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Sept. 16,	9. Birth Vi	place (State or Foreign ntry) rginia
	Maryland a-f show lied at	tor	10a. State 10b. County 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leading 10c. City, Town or Leadin				10d. Inside City Limits 1 XYes 2 □ No
	th with the 23a or 28a	Funeral Director	10e. Street and Number 1900 Rosemont Avenue	101. Zip Code 21702	10g.	Citizen of What Cou	ntry?
036	should be filed within 72 hours after death with the Maryland nd Menial Hygiene. Tratural, or items 23a or 28a-f show marked other than 'natural', or items 23a or 28a-f show imatic event, it a Maritgal Examinar manile modified at	þ	11. Marital Status  1 Never Married 2 Married  1 Ves Give  Year or Dates:  12. Was Decedent Ever in U.S.  A med Forces?  1 Ves Qual to  If Yes, Give  Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes XXNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	
Maryland 21215-0036	d within 72 h giene. er then *natu	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) PPET	ing 16b	Food Ser	
yland	should be file ind Mental Hy s marked oth umatic svsnt	To Be (	17. Father's Name (First, Middle, Last) Frederick Newton Pangle		e (First, Middle, Maid e Pear1 Gh		
Š	od 2 lith al 27 is r trau		Mrs. Jean Renee' Ribot, Daughter 17		Frederick,	Md 21701	
Baltimore,	permit, Pages 1 ar Department of Hea Importent: If item any injury or othe		A Donation 5 Other (Specify)  Resthaven	osition (Name of ematory or other place)  Memorial Gardens May 2		Frederic	
Ba	Depar Impor sny in		MUUZ55	Keeney and Basford 106 East Church St	., Freder	cal Home	1701
3760, <	Physician physician physician and physician with physician and physician and physician and physician and physician and physician and physician and physician and physician and physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician p	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one dause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to limit ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):				Approximate Interval Between Onset and Death O Close
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DIVIS	5 # 5 E	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	al Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	ledical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal check only and manner stated.	nvestigation, in my opinion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as s and place, and due to	tated. the cause(s)
)	With To T	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
	5		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	cherit	md2	1711
	Sta Registr	_	31. Date filed (Month, Day, Year) 4 2006 32. Registrar's Signature	books			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** HAZEL MARIE UNGER 19, May 2006 1:44 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Laurel Regional Hospital Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year JULY 3, 1 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 1 X F Yrs. 85 1920 Virginia 224-14-1944 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or Items 23s or 28s-f show the Wedgal Examinar must be notified at 1 ☐ Yes XXNo Laurel MD Prince George's Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20708 USA 11714 S. Laurel Drive death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Item any injury or other traumatic event, the Medical Examinations. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No þ 3 ♥ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Black J. Foy Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry Unger/Son 8415 Montpelier Drive, Laurel, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rimer Hill Cemetery 5/24/2006 AR1 Templeton, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease /Medical Due to (or as a consequence of): Examiner Hyperlipidemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filiate in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cellulitis Left Knee 1 ☐ Yes 2. ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2X No 1 ☐ Yes XIX No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Dther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D14220 May 22, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 9811 Mallard Drive, Laurel, MD 20708 Suite 205 Neil D. Meade 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 4 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1224 PM **Physician** Na VINEBERG CHARLES /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital of Baltimere N/A Tinai Baltimer If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) ANADA 8. Date of Birth (Month Pay 1918 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min 1 M 2□ F 87 Yrs 165-07-6051 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 □ No N/A BALTIMORE MD Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number is 1 and 2 should be filed within 72 hours after death with of Heath and Mental Hygiene. Item 27 ie marked other then "netural", or Items 23s or other traumatic event, Ite Medical Examinationals. USA 6317 PARK HEIGHTS AVENUE #517 21215 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RETAIL OWNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (UNKNOWN) VINEBERG JENNY LOUIS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6317 PARK HEIGHTS AVE. #517 - BALTIMORE, MD 21215 CORINNE VINEBERG / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Depertment of H
Important: if Itel
eny injury or ott t X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/23/2006 OWINGS MILLS, MD HAR SINAI CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition EMbolism Physician clay. resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown 1□Yes 2□No euhemia Completed 24b. Were autopsy findings available prior to completion of cause of death? Altery 0100014 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Death 1 ■Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation s after deau. eai Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Mie of H0062850 May 21, 2006. 30. Name and address of person who completed cause death (Item 23a) (Type, Print) Demuth rancis 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2006 MAY 2

DHMH 17 Rev 1/2001

Registrar

Marks

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Donald Frederick Williams, Jr. May 3, 2006 2:03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital ff Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 8,1930 Birthplace (State or Foreign Country) **Funeral** Months Days 1⊠M 2□F Hours Yrs. Director Virginia 229-34-9442 Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show troumstic event, the Medical Examiner must be notified at 1X Yes 2 No Directo MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16010 Excalibur Road Apt. D318 20716 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bfack, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. Atlantic Auto Elementary/Secondary (0-12) Colfege (1-4or 5+) Oxon Hill, MD Master Mechanist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill treent of Health and Mental H tant: If Item 27 is marked of Be Donald Frederick Williams, Sr. Phyllis Corthelia Banks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other tree once. Thelma J. Williams/Wife 16010 Excalibur Road, Apt. D318, Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ₺ Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Good Hope Cemetery 5/10/06 Front Royal, VA 22. Name and Address of Facility Stover Funeral Home, Inc. 21. Signature of Funeral Service Licensee) 177 N. Holliday St., Strasburg, VA Ameur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or heart failure. List only one cause on sight line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) avoreces /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to intrinediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. been signed by the s should be detached 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Completed | 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate hes al director, page 2 autopsy performed? 1 ☐ Yes 2⊠ No of Vital After this certification, I Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 ☐ fnpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred Certification: Division 1 X Naturaf 5 Pending To the Hospital or Attendir within 24 hours efter death. To the Funerel Director: At completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Carefying Physician: To the second stated.
2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) 45203 30. Names address of person complete suse of death (Item 23a) (Type, Print) Smith, M 7600 Carroll Avenue, Takora Park, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

James Terry Washington

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 16373

		- For State Registrar		Cert	ificate o	f Death			R	Reg. No		UU	U 100	1
Physiciai ledical Examin	n/ 1	Decedent's Name (First, Middle)		2017		Wash	ingto		Date of Dea Month	Day	Yea		3. Time of Death 1245 hrs	
Todical Examini	,	James 4a. Facility Name (if not institutio	Ter on, give street and number)			4b. City, Town,			May 21, 2		c. County o	of Death		_
		3902 Dolfield Avenue				Baltimore								
Funeral Director		5. Social Security Number 216-86-1390	6. Sex 7. Ag	ge (In yrs. Ias 38	st birthday) Yr:		ear If Unde ays Hours			irth(MN <b>24</b>	67	Foreign	nplace (State or n MD	
10 2 M		Usual Residence of Decedent					<u> </u>							
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ffer de		3 Widowed 4 Div	/orced If Yes, Give Year or Dates:	X No	1	Yes 2X	lo specify:				Specify:	В	lack	
ours a	g p	15. Decedent's Education (Spe	ecify only highest grade cor			nt's Usual Occup				16b.	Kind of Bu	siness/Ir	ndustry	_
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5-00; led with Hygiene other ti	<u>E</u> -	17. Father's Name (First, Middle.					_		irst, Middle,	Maider	1 Surname)	)		_
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than e event, the Medica	_	Robert J. Sm	ith						anley					
hould and Mer is man	<b>⊢</b> ]	19a. Informant's Name/Relations			19b. Mailir	ng Address (Str	eet and Num	ber or Rur	al Route Nu	mber, C	City or Town	n, State,	Zip Code) 21215	
		Reba Johnson 20a, Method of Disposition	-Mother	20b. PI		sition (Name of			Daite		Location -			
Baltimore, MD 2121  bernit Pages I and 3 should be fi  Cepartment of Health and Mental Important: If iten 27 is marked injury or other traumatic event,		1 X Burial 2 Cremation 4 Donation 5 Other S		ate cr	ematory or o		,		7/06	1		-	e, Md	
Baltimore permit Pages   Department of P Important: If injury or other	V	2) Signature of Funeral Service	Licensee	n t		Name and Addre			Ral+	imo	ore.	Md	21215	Ĭ
Physician	1	23a. Part I. Enter the disease, or failure. List only one cause											Approximate Interval	
/Medical Examiner		Imm diate Cause (Final disease	0	d heroi	n intox	ication							Death Death	
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68760, certificate be e nding physicia se as the buria	≥ □	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome							23	Bd. Date of			
CO = 20 co	icia	past 12 months?	4 Pregnant at	t time of dea	41-	etal death 3 ther (Specify)	B [Ectopic	pregnanc	y		Month	Di	ay Year	
the death of the attenty the attenty the attenty.	Phys	Part II. Other significant condit	9 OUKNOWN	th but not res	sulting in the	underlying cause	e given in Pa	ırt I	23e. Did t	obacco	use contri	bute to t	he cause of death?	_
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Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been is led in by the funeral director, page 2 should	ion :	27. Manner of Death  1 Natural 5 Pen	28a. Date of Inj. (Month, Day,) ding Fnd 5/21	Year)	28b. Time of Fnd 12:	· · ·   _	jury at Work Yes 2 🗶	. 1	ad. Describe unk	how in	Jury occurre	ed		
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Divisior Sepital or Attend hours after death, meral Director: y filled in by the	Certification:	3 Suicide 6 X Cou	ermined (Specify) fo	und at	residen	ce		В	altimor	e, M	3902 D	olfie	eld Ave.	
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		-	For State Registrar	State of Maryla	nd / Depa		t of H	ealth a		ental Hy		006	No. of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of	6374
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	and w		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	cation							10d. I	nside City Limits
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Maryland 21215-0036	should and Men a marka tumatic		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Maili	ng Address	(Street a	and Numbe	or or Rura	l Route Numbe	ar, City or	Town, State	, Zip Coa	(e)
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Baltimore,	permit. Pages Department of H Important: If Its any njury or of		21. Signature of Funeral Service Licence  Roll	land y	11:	201 1	Dund	lalk	Ave	. Balt	imo	runer re, M	d.	llone,PA 21222
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	lications that caused the de ne cause on each line.	ath. Do not en	ter the mod	de of dyin	g, such as	cardiac c	r respiratory a	rest,		inte	oroximate erval Between
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	/Medical		resulting in death)	a CARDIO  Due to (or as a conse	equence of):									
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Sic	ttand death tor: ,	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home farm st			103 2	-	28f. Location (	Street and	d Number or	Rural Ro	ute Number.
Division of	or A after Dirac in by	Certification;	4 Homicide determined	building, etc. (Spe	cify)	1001, 100101	y, onioo			City or To				
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	24 h 24 h a Fur	edical	(Check only 2 Medical Exam one)	iner: On the basis of exami and manner stated.	nation and/or in	nvestigation	n, in my o	pinion, dea	th occurr	ed at the time,	date and	place, and d	ue to the	cause(s)
	To the Within To the	Me	29b. Signature and title of certifier			29	c. Licens	e number			29d. Dat	e signed (Mo	nth, Day,	Year)
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	6		30. Name and address of person who co	completed cause of death (It	em 23a) (Type	, Print)	o Nai	en wi	UFE	STROET.	BAU	MORE,	MARY	WHY 21287
	St Regist	ate '	31. Date filed (Month, Day, Year) MAY 2 4 2006	32. Registrar's Sig	nature	R.								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) MAY 20, 2006 **Physician** 11:40pM DARNELL WHITE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner GLEN BURNIE ANNE ARUNDEL 329 ADDISON DR. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7-4-1950 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 □ F MARYLAND 55 220-56-0010 Yrs. Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "naturel", or items 23s or 28e-f ehow the Medical Examiner must be notified at 1 XYes 2 No Director ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 329 ADDISON DR. 21060 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married BLACK 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) LONGSHOREMAN PORT OF BALTIMORE njury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 Ie marked o LORETTA WILLIAMSON HERMAN WHITE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PRISCILLA WHITE(WIFE) 329 ADDISON DR. GLEN BURNIE. MARYLAND 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State CARPENTERS HILL 5-26-2006 SEVERNA PARK, MD. 4 Donation 5 In ther (Specify) 21. Signature of Fundral Service Licensee BARRY REESE 22 Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. any in eese 821 WEST ST. ANNAPOLIS, MARYLAND 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death BNEWMONTA Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical COLON CANCER Examiner METAST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2500 this certificete has 1 ☐ Yes 25. Was case referred to medical 26. Place of Death | Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation hours after death unerel Director: the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funerel C 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-22609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FURNACE BRANCH Rd GLEN BURNEMA 21060

Registrar DHMH 17 Rev 1/2001

State

REI

M.D

7445 32. Registrar's Signature Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a per doc 8555-24-06 vt. State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month . **Physician** 0855 AM HELENA WILKERSON 300E /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE N/AUNION MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛛 F Director 214 40 2297 MD Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 1 ☐Yes 2 ☐ No Director BALTIMORE MD. WINDSOR MILLS 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8049 WOODGATE COURT APT.D 21244 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give^X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□Yes 2□No Specify: Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) llTH HOMEMAKER HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be RICHARD BYERS SARRETA TROGDYN ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WINDSORMILLS, MD. BARBARA BARNWELL(DAUGHTER) 8049 Woodgate Court apt.D 20a. Method of Disposition 20b. Place of Disposition (Name of pemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ⊈8urial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST VET. MAY 24, 2006 WINGS MILLS MD. 4 □Doparton 5 □Other (Specify) 21. Significant of Funeral Service Licenses ČALVIN B. SCRUGGS FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTO, MD. Approximate Interval B-tween Onset a.v. Death Immediate Cause (Final Grmany Munz Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and state is the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as the ettending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 more 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No certificate 2 **X**No 1 Yes Atte.
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the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident within 24 hours after deal To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide o the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of deti Cernan 21208 32. Rastrar's Signature 31. Date filed (Month, Day, Year) State 4

DHMH 17 Rev 1/2001

Registrar

2006

		•	1 - For State Registrar	State of Maryland		rtment of H		Mental Hy	giene Reg. No.	006	16377
			Decedent's Name (First, Middle, La	st)				2. Date of De	ath		3. Time of Death
н	Physici		CARRIE P.	YOUNG				MAY	Day 2	2 006	11:30 AM
,	/Medio		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deat	h		County of Death	1
			St Agnes t	tospital		Balt	more		ı	N/A	
	Funeral		5. Social Security Number 6. S			If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth ay, Year)	Cou	place (State or Foreig
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	and *		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
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	ms 2:	by Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	. 13. V	Vas Decedent of H		pecify Yes or N		4. Race - Amer	
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•	permit. Pages 1 and 2 Department of Health a Importent: if item 27 ii any injury or other tre once.		MARGARET BRYAN  20a. Method of Disposition	20b. Pla	ice of Dispos	sition (Name of		Date		cation - City or T	
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;	tend death tor: , the f	cat	2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could not I				Yes 2 ☐ No	291 Location	(Stroot and	Ahumbar as Pu	ral Planta Alumbar
	or Al	i.	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, rarm, stre	eet, factory, office		City or To	wn, State)	Number or Hul	ral Route Number,
I	To the Hospital or Attending Physicien: The I within 24 hours effer death.  To the Funerel Director: After this certificate he completely filled in by the tuneral director, page.		20a Cartifiar 1 Cartifuling B	hysician: To the best of my knowl	ledge doath	occurred at the time	ne data and place	and due to the	Called(a)	and manner at	stated
	Hos. 24 ho Funi	Medical		hysician: To the best of my knowl miner: On the basis of examinatio and manner stated.							
	ithin i	Mec	29b. Signature and title of certifier	कार्य विशासिक उद्गिष्टिय		29c. Licens	e number		29d. Date	signed (Month)	, Day, Year)
	£ ≩ £ 8			even, MD		PIZ	495			/21/2	
	$\sim$		30. Name and address of person who		23a) /Tuna	Print)				, ,	
	,9	1	Samina Vini	maram Gas	O CAL	Da A -0	bal+	more.	MI	> 212:	29
	St	ate	31. Date filed (Month, Day, Year)	masiam, 90 E 32. Registrar's Signatu	ire	· · · · · · · · · · · · · · · · · · ·		- /			
	- 31	100	4			A marine					

DHMH 17 Rev 1/2001

ORIGINAL

Carilyn ANTHONY	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary
		Pr / E:
	ecords, P.O. Box 68760,	law requires that the death certificate be executed

/Medio	an 🏻	1 - State RegistreAmend#'s 20b.c.PerFH PCC 5-15-06cr  1. Decedent's Name (First, Middle, Last)  Carolyn Diann Anthony		2. Date of Death Month	Day JOEG	3. Time of Death
		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	
		Doctors Community Hospital	Lanham		Prince	
Funeral Director		5. Social Security Number  577-58-6602  G. Sex  1 □ M 2 □ F  7. Age (In yrs. last birth  59  Yr  Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 10,		place (State or Foreig intry) Sh, DC.
MO III		10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
netifiedat	cto	Maryland Prince George Temple	Hills			Yes 2 ☐ No
at be no	al Dire	10e. Street and Number 3420 Ricky Ave. #242	10f. Zip Code 20748	, -	Citizen of What Cou United Sta	•
	ā	Maryland     Prince George     Temple       10e. Street and Number     3420 Ricky Ave. #242       11. Marital Status     #242       1 □ Never Married     2 □ Married       3 □ Widowed     4 ☒ Divorced    Temple  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto     □ Yes 2▼ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: B1	, etc.
	Completed	(Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of worki ife. DO NOT use retired)	ng 16t	b. Kind of Business/II	ndustry
	Com		lephone Operator		Private	
C	To Be (	17. Father's Name (First, Middle, Last) Hammie Wilson		(First, Middle, Maile Davis	den Sumame)	
other traumatic event,			Mailing Address (Street and Number or Rura 04 Manchester Way; E			p Code)
		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State LResurre	edmiterror etenniace)	200 Cl	Location - City or T inton, Md	own, State
any injury or other		4 □ Donation 5 □ Other (Specify)  21. Signature Funeral Service License		pe Funera 38 Maribo restville		747
the burial-transit	icai Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of)  Cue to (or as a consequence of)  Due to (or as a consequence of)				
10	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv	ery Day Year
ō		Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobaco	co use contribute to t	
e detached for	by	Partition of the significant containing accommoding to death out not resulting and	ne underlying cause given in Part I.	1 Yes	2 No 3 Pro	he cause of death?
ate has been signed by the atte page 2 should be detached for	Completed by P	Farth. Other significant containing continuously to dealth out not resulting in the	ne underlying cause given in Part I.	1 Yes  24a. Was an autopsy performed 1 Yes 2 12	24b. Were auto prior to co death?	opsy findings available impletion of cause of
ate has been signed by the atte page 2 should be detached for	Be Completed by	25. Was case referred to medical examiner?	26. Place of Death	24a. Was an autopsy performed 1 Yes 2 12	24b. Were autoprior to condeath? No 1 Yes	pably 4 Unknown
Atter his certificate has been signed by the after funeral director, page 2 should be detached for	To Be Completed by	25. Was case referred to medical examiner?  1   Yes   2   No	26. Place of Death atient 3 DOA Other: 4 Nursing Hon ne of 28c. Injury at Work?	24a. Was an autopsy performed 1 Yes 2 12	24b. Were autoprior to codeath? No 1 Yes	pably 4 Unknown
After this certificate has been signed by the atte funeral director, page 2 should be detached for	To Be Completed by	25. Was case referred to medical examiner? 1  Yes 2 No  Hospital: 1 Inpatient 2 EP/Outp. 27. Manger of Death 28a. Date of Injury 28b. Time	26. Place of Death atient 3 DOA Cther: 4 Nursing Hon the of Work? M 1 Yes 2 No	24a. Was an autopsy performed 1 Yes 2 12 Check only one ne 5 Residence 8d. Describe how in	24b. Were authorior to condeath? No 1 Yes  26 Other (Special prior) occurred	popably 4 Unknown opsy findings available impletion of cause of 2 No
After this certificate has been signed by the atte funeral director, page 2 should be detached for	dical Certification: To Be Completed by	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Columnot be detailed a summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of the summer of	26. 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ate has been signed by the atte page 2 should be detached for	ledical Certification: To Be Completed by	25. Was case referred to medical examiner?  1   Yes   2   No	26. Place of Death atient 3 DOA Cther: 4 Nursing Hon the of Work?  M 1 Yes 2 No  1, street, factory, office	24a. Was an autopsy performed 1 Yes 2 12 Check only one ne 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street City or Town, Street	24b. Were autoprior to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to except to exc	popably 4 Unknown  opsy findings available impletion of cause of  2 No  (y)  al Route Number,  stated. o the cause(s)

			1 - Stata Registrar	State of Marylar		rtment of H		d Mental Hy	/giene Reg. No.	ZUUA	16379
	Physici /Medio		Decedent's Name (First, Middle, Last)     Mohammed	Mahdi Ab	dulwah	nab		2. Date of D Month 4	Day 26		3. Time of Death 7:26 a ^M
	Examir Funeral		4a. Facility Name (If not institution, give s  National Instit  5. Social Security Number  6. Sex	tute of Hea	last birthday)	4b. City, Town, or Rockvi.  If Under 1 Year Months Days	lle   If Under 24 F	Hrs. 8. Date of Bi	MC	ontgomes 9. Birthp Court	place (State or Foreign
	Director		256-37-3007  Usual Residence of Decedent  10a. State 10b. County		Yrs.	cation		7/7/1	956		LOPIA  10d. Inside City Limits
	ith the Mar or 28a-f sh e notified	Director	Md. Prince G		wie	10f. Zip Code			10g. Citi	zen of What Cour	1 ☐ Yes 2 💆 No ntry?
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any njury or other traumatic event, the Modical Examiner must be notified at ADEC.	by Funeral Director	12123 Quadrille  11. Marital Status	2. Was Decedent Ever in L Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	20720 Vas Decedent of H Yes, specify Cuba  ☐ Yes 2점 No	ispanic Origin? In, Mexican, Pt Specify:	(Specify Yes or Nuerto Rican, etc.)		Opia  14. Race - Americ Black, White,  Specify: bla	etc.
Maryland 21215-0036	ed within 72 hou /giene .or than "natura t, the Madical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give I life. D	ent's Usual Occup kind of work done o DO NOT use retired ician	during most of	working	Co	nd of Business/Ind rrectio cility	
ryland	nould be file d Mental Hy narked oth natic event	To Be (	17. Father's Name (First, Middle, Last)  Mahdi Abdulwah		401.14.77		Mariu		, Maiden nim	Sumame)	
ore, Mai	es 1 and 2 st of Health and f Item 27 Is r ir other traur		19a. Informant's Name/Relationship (Typ. Nabila Abdulwah  20a. Method of Disposition 1 Rugurial 2 Cremation 3 CRe	ab/wife	1212	3 Quadr	ille I	Aural Route Numb	wie	, Md. 2	0720 own, State
Baltimore,	permit. Pages Department of I Important: If Ite any injury or of page.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	was	22.	Name and Address	ss of Facility [	4/28/06 Jniversa	l Mo	ortuary	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	th. Do not ente	r the mode of dyin	g, such as card				Approximate Interval Between Onset and Death
8760,	ate be executed nysiclen and he burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	uence of):						18 years
O. Box 6	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Sc. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of a 9 Unknown	ıl death 3 □I	Ectopic pregnancy Other (specify)			2	3d. Date of delive Month	ory Day Year
rds, P	The law requires that the see has been signed by the page 2 should be detached.	þ	Part II. Other significant conditions cont	inbuting to death but not res	sulting in the un	derlying cause give	en in Part I.				e cause of death? ably 4 □Unknown
Vital Records,		Completed						24a. Was auto perfo 1 Yes		prior to con death?	psy findings available mpletion of cause of 2 No
Division of Vit	Attending Physician: r death. ector: After this certific by the funeral director.	atlon; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	ar: 4 ☐ Nursing	g Home 5 Resi	dence 6		)
DIVIS	2 4 5 6	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location ( City or To	Street and wn, State)	l Numb <b>e</b> r or Rural	Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical Examinone)	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation and/or inve	estigation, in my or	oinion, death o	ace, and due to the courred at the time,	date and	place, and due to	the cause(s)
0	5 × 5 × 5		29b. Signature and title of certifier	aud		29c. License	3154	5	5 /l	o signed (Month, C	Эву, Year)
	Sta	te	30. Name and address of person who con  ATMY  31. Date filed (Month, Day, Year)	npleted cause of death (ften		10 Ca	enter	Drive 1	sein	enda MI	20892
	Registr		MAY 1 0 2006	Breite &	Since.	5					

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

itams to the 28f Certificate of Death and Mental 105

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	11	: ">		5	3	1	
-	200	A. Salah	1	12	10	1	- \

		1. For State Amended items 4a,4b,28f Certificate of Death per me/wich	d/05-16≃	2006/dls	0 1038			
Physici Medical Exami	an/	1. Decedent's Name (First, Middle, Last)  William Elliott Austin Sr.	2. Date of Death	Day Year	3. Time of Death 1050 hrs			
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. City, Town, or Location of Death  4c. City, Town, or Location of Death  4c. City, Town, or Location of Death  4c. City, Town, or Location of Death  4c. City, Town, or Location of Death  4c. City, Town, or Location of Death  4c. City, Town, or Location of Death  4c. City, Town, or Location of Death  4c. City, Town, or Location of Death		4c. County of Death Wicomico	1			
Funeral		8838 Sandpebble Court 8688 Sandpebble Court Wicomico Hebro  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs,	R Date of Right	n(MM/DD/YYYY) 9. Bir	thniaco (Stato os			
Director		212-54-7770 1X M 2 F 55 Yrs. Months Days Hours Min.	03/19	/1951 Foreig				
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
<b>*</b> .		Maryland Wicomico Hebron		İ	1 Yes 2 X No			
Maryland 28a-f show d at once.	cto	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cour	ntrv?			
ith the Maryland 23a or 28a-f sho notified at once	Director	8688 Sand Pebble Court 21830		USA	,			
th with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 X Married		14. Race - Ameri White, etc.	can Indian, Black,			
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	by Fun	Never Married 2 X Married 1 Yes 2 X No 1 Yes, Give Year or Dates:	rtiodii, etc. j		hite			
5-0036 led within 72 hours afte Hygiene other than "natural", the Medical Examiner		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retire		16b Kind of Business/I	*			
6 3 🗇	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		United Par	rcel			
15-0036 filed within 72 I Hygiene do other than '	om	12 2 Loader  17. Father's Name (First, Middle, Last) 18. Mother's Name	(First Middle M	Service				
21215-0036 wild be filed within 7 Mental Hygiene marked other than c event, the Medica	Be C		ne (First, Middle, Maiden Surname)  Marie Dean					
21215 ould be file d Mental H s marked o	70	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or R			, Zip Code)			
nore, MD 2 ages I and 2 shoul nt of Health and M II. If item 27 is n other traumatic		Tina Marie Austin/wife 8688 Sand Pebble Cou	ırt, Heb	ron, MD 218	330			
ore, es lan of Hea friten her tra		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)		Town, State				
imo Page nent c tant: or oth		4 Donation 5 Other Specify: Salisbury Crematory 5/	12/06	Salisbur	-			
Baltimore, permit Pages I as Department of He Important: If ite	-	Signature of Funeral Service Licensee  22. Nema and Address of Facility ral 501 Snow Hill Rd.	ofessional	Association				
	- 3	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	, Salis	oury, MD 2	L804 Approximate Interval			
Physician /Medical	/Medical failure. List only one cause on each line.							
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Gunshot Wound to Chest  Due to (or as a consequence of):		Death				
		Sequentially list conditions, b.						
	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause						
ed sit	Examiner	events resulting in death) Last Due to (or as a consequence of):						
3760, ficate be executed g physician and sthe burial - transit		d. UNPENDED AMENDED	-					
60, ate be hysici e buri	//Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery				
	an/I	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant	псу		ay Year			
Box 687 he death certific to the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending perfect of the attending per	Physiciar	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown 9 Unknown		1				
by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e, Did tob	acco use contribute to t	he cause of death?			
ires that the signed by the detached	l by		1 Yes	2 No 3 Prob	ably 4 Unknown			
ords, w requir s been s should!	Completed		24a Was an		opsy findings available			
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Division of Vital Records, tal or Attending Physician: The law requir rs after death al Director: After this certificate has been seled in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	ertification	3 ✓ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Str	reet and Number or Run	al Route Number, City			
Divi spital or hours afte neral Dir	Çe	4 Homicide Single Family	Sandpe	bble Court, Hebro	on, MD			
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and of one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at						
To witi	Mec	and manner stated  29b Signature and title of certifier  29c. License number		29d. Date signed (Mon	th, Day, Year)			
		(a had the look oc.m.e.		May 11, 2006				
1/2		30. Name and address of person who completed cause of death (Item 23a)						
Pa		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
	ate	31. Date filed (Month, Day, Year) 32. Resistrar's Signature						
Regis	i Eli	MAY 1 6 2006 Bloom A. Aparte						

For Amend Item//11 State of Manyland / Department of Health and Mental Hygiene 2 0 6 6/9/06 Consister Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** M MAY 09, 2006 1350 DOROTHY MAE BUCKMON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **GEORGES** PRINCE SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2**X**F Yrs. Director 578-40-0873 SOUTH CAROLINA May 25, 1926 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 □ No Director Temple Hills Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Edgemere Drive 20748 U. S. A. 6722 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Day Care Provider 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be CLAUDIA **ESAW** TOM ROBIN or of Health and M If Item 27 is man or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1707 Bay Berry Terrace Bowie, Maryland 20721 Jacqueline Caldwell-Daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if Ite
any Injury or oti May 15,2006 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial 5538 MARLBORD, PK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility POPE FUNERALHOMES Charles FORESTUTLLE, MD 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** ACUTE MYD CARDIAL INFARETION /Medical Due to (or as a consequence of): Examiner HYPERTENSION. S. puentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy be detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? the funeral director. Be 26. Place of Death Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 X ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 T Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) And & Malegin D50689 05/10/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTHERN MORY LOND HUDD TOL CENTER 7503 ANILK MAHAJAN. MO SUDDATTE ROOD CLINTON MD 20735 31. Date filed (Month, Day, Year) . Registrar's Signatur State MAY 1 1 2006 Registrar

06-03070 Dar

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Phy dical Ex	/sicia	ın/	Registrar  1. Decedent's Name (First, Middle,Last)  Darryl L	. Blalock			_		2. Date of Dea Month	th Day Year	3. Time of Death 1745 hrs
dicar E	kaiiiii		4a. Facility Name (if not institution, give street		41		vn, or Lo	cation of Dea	May 6, 20	4c. County of De	eath
Fun	oral		Southern Maryland Hospital  5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	Clinton	1 Year	If Under 24H	Irs. 8 Date of Bir	Prince Geo	•
Dire			578-98-1247 1X M 2		Yrs.	Months	Days	Hours M	lin		oreign Country) Wash, DC.
	апу	Ì	Usual Residence of Decedent  10a. State 10b County	10c, City, To	wn or Locatio	ก					10d. Inside City Limits
pue		5	Maryland Prince Geor	ge Upp	per Mai	rlbor	0				1 X Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.	23a or 28a-f show notified at once.	Director	10e Street and Number 6528 Rosemont St.			10f. Zip C	^{ode} 207	72	1	Og Citizen of What C United	Country? States
ath with	items 23a	Funeral		as Decedent Ever in U.S. med Forces?					Specify Yes or No to Rican, etc.)	14 Race - Ar White, etc	merican Indian, Black, c.
after dez	al", or i		3 Widowed 4 Divorced If Yes, C or Date	S'	1 🔲	Yes 2 🔀	No s	specify:		Specify:	Black
2 hours	"natur	ted t	15. Decedent's Education (Specify only higher Elementary/Secondary (0-12) Col	est grade completed) 16 lege (1-4 or 5+)	Sa. Decedent's during mos			(Give kind o O NOT use re		16b. Kind of Busine	ess/Industry
036 within 7	d other than "natu , the Medical Exan	Completed by	12th		Barber	c					vate
215-( e filed v etal Hygi	ked oth	Be Co	17 Father's Name (First, Middle, Last)  Leroy Blalock						ne (First, Middle, I a Hintor	Maiden Surname) 1	
AD 21 2 should 1 1 and Mer	27 is marked smatic event,	٢	19a Informant's Name/Relationship (Type, Pri Leroy Blalock/Father							nber, City or Town, S hington, I	
ore, N s 1 and of Health	tant: If item 27 is or other traumat	Ì	20a. Method of Disposition  1   Burial 2 Cremation 3 Rem		ce of Disposit matory or othe		of cemet	tery,	Date	20c. Location - City	y or Town, State
Baltimore, permit. Pages I and Department of Heal	y or oth		4 Donation 5 Other Specify: 21. Signature of Funeral Service Disease		ar Hil				12,2006	Suitland	-
<b>Ba</b> perm Depa	Impe		with	whell	Pope	e Fun	era1	Homes	, 5538 M	ſarlboro P	k.Md. 20747
Physic /Med	lical		23a. Part I. Enter the disease, or complications failure. List only one cause on each life.		o not enter the	e mode of	dying, su	ch as cardiad	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
Exam	iner			or as a consequence of):							
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e execul	physician and he burial - transit	dical	UNPENDED AMEN	NDED					-		<del></del>
8760 ificate b	ng physi	n/Me	23b. vvas decedent pregnant in the	If yes, outcome of pregnar		al death	3	Ectopic preg	nancy	23d. Date of deli Month	very Day Year
Box 687 death certific	e attending phy I for use as the l	ysician/	past 12 months?  1 Yes 2 No 9 Unknown 9	Pregnant at time of death Unknown	_ =	er (Specify		, . , .	,		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	signed by the I be detached t	by Phy	Part II. Other significant conditions contrib	uting to death but not resu	ılting ın the ur	nderlying ca	ause give	en in Part I	process		e to the cause of death?  Probably 4 Unknown
<b>rds,</b> require	has been sig	leted							24a. Was	an 24b. Were	e autopsy findings available to completion of cause of
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/ital   sician:	this certificate Il director, page	o Be (	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	1 Inpatient 2 EF	R/Outpatient		0.	Death (Chec	sk only one)	Residence 6 0	ther:
of √ Jing Phy	After	-	27. Manner of Death	(Month Day Year)	8b. Time of In	jury 28	_	at Work?		how injury occurred t collided with	
Division Hospital or Attendir 24 hours after death	irector: n by the	Certification	2 Accident Investigation 28	e, Place of Injury - At home		, factory, c		ding, etc			Rural Route Number, City
Div spital o	filled i	Certi	4 Homicide determined (S	pecify) Major Road /	Highway				N/B Douerh	State) louse Road, Upp	oer Marlboro ,
To the Ho within 24	To the Fu	Medical	29a. Certifier (Check only one)  2 Medical Examiner: On the								
F W	<u>-</u> 5	Me	29b. Signature and title of certifier	/ In			icense r		-	29d. Date signed (	(Month, Day, Year)
16			30. Name and address of person who complete	ed cause of death (Item 23	Ra)		D.C.M.	E.		May 7, 2006	
THU!				nt Medical Examiner	111 Pe	nn Stre	et, Balt	timore, MI	21201		
	St	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signature	Rock						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- Stata
Registra Amend Item #17&18 Per FH G856 65728406 of peath Rag. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Susie Baker May 08, 2006 6:40 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Waldorf Healthcare Center Waldorf Charles Co. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2 😾 F Yrs Director 82 Nov.23,1923 241-88-4569 North Carolina Usuel Residence of Decedent with the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 7 ie marked other than "naturel", or iteme 23a or 28a-f ehow traumatic event, the Madical Examinar must be notified at N☐ Yes 2 ☐ No Director Maryland Charles Co. Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6773 Lantana Drive 20616 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Completed by Specify: **X**☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jessie Cook Bennie Dunston Paul Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie Anderson / Daughter 6773 Lantana Dr. Bryans Road, Maryland 20616 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Saint Delight Cem. 5/13/2006 Louisburg, NC 21. Signature of Funeral Service Licensee Alexander S. Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, Maryland 20747 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIOMYOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of) TRS Examiner PERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CHRONIC 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 😾 No Physicien: 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: Other: 1 ☐ Yes 2 🙀 No 1 Inpatient 2 | ER/Outpatient 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred al or Attending P after death. I Director: After I d in by the funera After 1 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospitel within 24 hours a To the Funeral Completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled in a second completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature ang title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) HENDIN ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 102 Paul Mellon Ct. Waldorf, Maryland 20602 Suite102 Ashton Patel

State Registrar Dr.

31. Date filed (Month, Day, Year) MAY 1 2 2006



		•	For State Registrar		Cei	rtificate of D	eath	Re	g. No.	00	
			Decedent's Name (First, Middle, Last	")				2. Date of Death Month	Day	Yeer	3. Time of Death
	Physici /Medio		WILLIAM ROWLAND	BRACKETT				May 9.	2006	1001	4:11 a M
1	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or I	ocation of Death		4c. County	of Deeth	
			Heartland of Ade	1phi		Adelphi			Princ	e Ge	orge's
	Funeral		5. Social Security Number 6. Se	7M 2015	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	<ol><li>Date of Birth (Month, Day,</li></ol>			olece (Stete or Foreign htry)
	Director		214-05-0426 Usual Residence of Decedent	<u>g</u>	)2 Yrs.			July 18,	1913	Mar	yland
	land bw		10a. State 10b. County	100	c. City, Town or Lo	ocation				1	10d. Inside City Limits
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	r 288	irec	10e. Street and Number		)	10f. Zip Code		10	g. Citizen of V	Vhat Cou	ntry?
	h with	al D	1801 Metzerott R	oad		20783			U.S.A.		
	deat	Funeral Director	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe Mexican, Puerto	cify Yes or No- Rican, etc.)		e - Ameri	ean Indian,
98	or it	F	1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give	1942-	_	Specify:		Specify	<i>'</i> :	
8	72 hours after death with the Maryland natural', or items 23a or 28a-1 ehow areal Examena must be notified at	d by	3   Widowed 4 □ Divorced		1945					Who	
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an	Mental Mental Ked o	To B	James Frank Brac	kett			Amanda J	acobs			
Maryland	should and Men marke	<b>-</b>	19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Street ar			City or Town,	State, Zip	Code)
	and 2 salth a n 27 is		Mary V. Lynch -						arylan		
ore	of He of He fiten		20a. Method of Disposition 1 X Burial ≥ Cremation 3 □		Ob. Place of Dispo cemetery, crea	osition (Name of matory or other place,		ete 2	20c. Location -	City or To	own, State
<u>Ĕ</u>	Pages ment of ant: If it ury or o		* 4 □ Donation   5 □ Other (Specify			ns Cemeter		/2006	Chelter	nham,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any fujury or other traumatic event, the Mudical Examiner must be notified at ONCE.		21. Signature of Funeral Service Licen:	ode /		2. Name and Address					
ш	705 g g		+oult (1	sville	, MD						
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only						st,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Adva	nced S	enile D	emenx	79.			IMPHY YOS
3	/Medical Examiner		1	Due to (or as a co	nsequenca of):	enile D Disea	C@				~~~ ·
		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	nsequence of):	21364	ع د				ros ay yes.
	uted d ansit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
Ď,	ficate be executed physician and is the burial-transit	Exa	resulting in death) Last	Due to (or as a co	nsequence of):			, , , , , , , , , , , , , , , , , , , ,			
68760,	te be ysicia ne bur	cai	(	d							
			IF FEMALE:		<del>.</del>						
Вох	law requires that the death certi as been signed by the attending 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 Live birth 2 ☐	Fetal death 3	Ectopic pregnancy			23d. Dat	e of delive	ery Day Year
	the all	sici	1 Yes 2 No	4□Pregnant at time 9□ Unknown	of death 5	Other (specify)					
P.0	hat the	Ph)	Part II. Other significant conditions co	ontributing to death but no	ot resulting in the u	inderlying cause giver	in Part I.	23e, Did tob	acco use cont	ribute to t	ne cause of death?
ds,	w requires that been signed to should be det	l by	Chronic Obs						s 2 No	3 Prot	
Ö	v requ	etec	Pulman Do	udocyst	6050	A	1000	24a. Was ar	24b 1	More auto	psy findings available
Rec	0 - 0	Completed by	100000000000000000000000000000000000000	e- Pasion,	12. 11	B 1/at	2 18	autopsy	/ [	prior to co death?	impletion of cause of
	Tate pa	8	Distase, MYPA	p-1 rusion,	1-19 HT	DUNGIEL	2000 13	Yes 2	Ø No 1	Yes	2   No
a	ë ¥ 5		25 Was case referred to medical	•				Chark anh an	-1		
Vita	rsician: Th s certificate director, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital: 1  Inpatient	2 □ ER/Outpatie	Other	26. Place of Death			er (Specii	(v)
of Vital Records,	Physician: this certific	To Be	examiner? 1 □ Yes 2 ☒ No  27. Manner of Death	I □ Inpatient	2 DER/Outpaties	nt 3 DDA Other	26. Place of Death  4X Nursing Ho	n (Check only one me 5 Reside 28d. Describe ho	nce 6 Oth		y)
ion of Vita	ting Physician: n. After this certific	To Be	examiner? 1 ☐ Yes 2 🔀 No	28a. Date of Injury (Month, Day Ye		nt 3 DDA Other	26. Place of Death  4X Nursing Ho	me 5 Reside	nce 6 Oth		<b>y</b> )
vision of Vita	ting Physician: n. After this certific	To Be	examiner?  1 Yes 2 No  27. Manner_of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Ye	er) 28b. Time o Injury	nt 3 DDA Other  of 28c. Injury Work?  M 1 TY	26. Place of Death  4 ☑ Nursing Ho at es 2 ☐ No	me 5 Reside	nce 6 Oth w injury occurr	ed	
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Division of Vita	ting Physician: n. After this certific	edical Certification; To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  29a. Certifier (Check only one)  2 No  2 No  6 Could not be determined	28a. Date of Injury (Month, Day Ye  28e. Place of Injury building, etc. (S	At home, farm, streecify)  y knowtedge, deat unination and/or in	nt 3 DDA Other  f 28c. Injury Work:    M 1 Y  reet, factory, office  h occurred at the time inexistigation, in my opi	26. Place of Death  4 \times Nursing Ho at at at as as a, date and place, nion, death occurr	me 5 Reside 28d. Describe ho 28f. Location (Str City or Town and due to the ca ed at the time, de	nce 6 Oth w injury occurr eet and Numb , State) use(s) and ma	er or Rura inner as s	al Route Number, tated. the cause(s)
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Division of Vita	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical Certification; To Be	examiner?  1 Yes 2 X No  27. Manner of Death  1 SNatural 5 Pending investigation  3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one)  29b. Signature applittle of certifier  30. Name and address of person who could be determined	28a. Date of Injury (Month, Day Ye  28e. Place of Injury building, etc. (S  ysician: To the best of miner: On the basis of example and manner stated.	At home, farm, stipecify)  At home, farm, stipecify)  y knowledge, deat imination and/or in	nt 3 DDA Other  f 28c. Injury Work' M 1 Y  reet, factory, office  h occurred at the time vestigation, in my opi	26. Place of Death  4 \( \) Nursing Ho at test of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second seco	me 5 Reside 28d. Describe ho 28f. Location (Str City or Town and due to the ca ed at the time, da	nce 6 Oth w injury occurr reet and Numb . State) use(s) and ma tte and place, a	er or Rura inner as s and due to	al Route Number, taled. taled. the cause(s)  Day, Year)
Division of Vita	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification; To Be	examiner?  1 Yes 2 X No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  29b. Signature apolitile of certifier  30. Name and address of person who	28a. Date of Injury (Month, Day Ye  28e. Place of Injury building, etc. (S  ysician: To the best of miner: On the basis of example and manner stated.	At home, farm, str pecify)  At howe, farm, str pecify)  y knowledge, deat mination and/or in	nt 3 DDA Other  f 28c. Injury Work' M 1 Y  reet, factory, office  h occurred at the time vestigation, in my opi	26. Place of Death  4 \( \) Nursing Ho at test of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second seco	me 5 Reside 28d. Describe ho 28f. Location (Str City or Town and due to the ca ed at the time, da	nce 6 Oth w injury occurr reet and Numb . State) use(s) and ma tte and place, a	er or Rura inner as s and due to	al Route Number, taled. taled. the cause(s)  Day, Year)

DHMH 17 Rev 1/2001

			1 - For State Registrar	State	of Mary	land / Dep <i>Ce</i>	artmen rtificate					Reg. No.	2006	16	385
	Physicia /Medic		1. Decedent's Name (First, Middle Helen Brow								2. Date of Dea Month Iay	-	h 2ď∜6		of Death 35pm
	Examin		4a. Facility Name (If not institution	give street and no	mber)		4b. City,	Town, or	Location o	f Death		4c. (	County of Death		
			Bradford Oal					nto				Pı	rince (		
	Funeral		5. Social Security Number 228-12-5519	6. Sex 1 ☐ M 2 🖾 F	7. Age (In 85	yrs. last birthday, Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birt (Month, Da July	h Y. Year)	9. Birth	olace (State otry)	e o <i>r Foreign</i>
	Director		Usual Residence of Decedent												
	72 hours after death with the Maryland natural; or ttems 23a or 28a-f show dical Examinat hust bu ruillisch at	-	10a. State 10b. County PG			c. City, Town or L emple H								10d. Inside 11X1 Ye	City Limits es 2 ☐ No
	he Ma	Funeral Director	10e. Street and Number				10f. Zip	Code				10a Citiz	zen of What Cou		
	with t	흡	3126 Brinkley	Statio	n Dr	ive	207					USA	LOTT OF TYTIAL COU	intry :	
	ns 23	era	11. Marital Status	12. Was Dec	edent Ever				spanic Orig	gin? (Spec	ify Yes or Noican, etc.)		4. Race - Amen		
9	I within 72 hours after death with the Marylan liene. I than "natural", or liems 23a or 28a-f show tra Madical Eraminar must be rutified at	Fur	1 Never Married 2 Marri	Armed F ed 1 Tes If Yes, G	2 X No		If Yes, spec 1☐ Yes 2		n, Mexican Specify:	, Puerto R	ican, etc.)	- 1	Black, White, Specify: B1 a		
21215-0036	nours,	d by	3 XWidowed 4 ☐ Divorced	Year or l	Dates:										
<u>.</u>	n 72 h	Completed	15. Decedent (Specify only highes	t grade completed		16a. Dece (Give	dent's Usua kind of wor DO NOT us	il Occupa k done d e retired,	ition <i>luring m</i> ost )	t of working	9	16b. Kir	nd of Business/Ir	dustry	
712	within in then represented in the Mexicology.	шо	Elementary/Secondary (0-12) 6th grade	College	1-4or 5+)		emake				i	Pvt	Indust	ry	
פַ	be filed ital Hygi of other event, I	Bec	17. Father's Name (First, Middle,								(First, Middle,				
ylaı		To E	Harrison John	ison				-		ie V					
	2 2 2 2		19a. Informant's Name/RelationsI Janie Brown (I		~ )								Town, State, Zij		1748 1d
	Health Health tem 27 other tr		20a. Method of Disposition			0b. Place of Disp	osition /Nam	ne of		Da	te	20c Loc	cation - City or T	own State	<u> </u>
JOL	A O		1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		State O	ak Grov	matory or of Pe Ba	pt (	Cem0	5-17 ⁻	th 06	Suf	folk V	a.	
Baltimore,	permit. Page Department ( Important: If any injury or once.		21. Signature of Funeral Service	icensee	2	1							ly St.	NW W	
			23a. Part1. Enter the disease or shock, or heart failure.	complications that	caused the each line.	death. Do not en	ter the mode	e of dying	g, such as	cardiac or	respiratory ar	rest,	ער	Approxim Interval B	ate etween
	Physician		Immediate Cause (Final disease or condition	,		Opic	por	14	OFI	He	OTER	US	× .	Onset an	d Beath
	/Medical Examiner		resulting in death)	Due to	(or as a co	nsequence of):									
		ē	Sequentially list conditions,	b. — Dua to	(or as a no	nsequence of):									
	uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c											
o	cate be executed physician and the burial-transit		resulting in death) Last		(or as a co	nsequence of);									
8760,	ate be hysici the bu	llcal		d											
9 x	death certificate be executed e attending physician and nd for use as the burial-transit	/Med	IF FEMALE:	23c. If yes, or	stcome of p	ragnancy		,				2	3d. Date of deliv	001	
Вох	atten atten	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 22 No	1 Live		Fetal death 3	□Ectopic pro □ Other (sp					2	Month Month	Day	Year
P.O.	at the de by the a tached	hysl	9 Unknown	9□ Unk	nown										
	es that igned to be deta	by P	Part II. Other significant condition	ns contributing to	death but no	ot resulting in the i	inderlying ca	ause give	n in Part I.		23e. Did to	_	se contribute to t		
ord	w require been si should t			-							101	(es 2 <b>6</b>	3 □ Pro	pably 4 [	⊒Unknown
Records,	2 5 2	Completed									24a. Was autop		24b. Were auto prior to co death?	psy finding mpletion of	s available cause of
alF											1 Yes	2 No	1 ☐ Yes	2□ No	
Vital	Physician: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner?	Hospital:	Innationt	2 ☐ ER/Outpatie	nt 3 DO	Δ Othe	1		(Check only o		Other (Speci	5/1	
0			27. Manner of Death	28a. Date	of Injury ofth, Day Ye			8c. Injury Work	100		3d. Describe			,,	
jo	Attending I r death. ector: After by the funer	atlo	1/2 Natural 5 Pendin 2 Accident investig	ation	iii, <b>Ju</b> y 70	,,	М		res 2 □ i	No					
Division		Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 286. Plac	e of Injury - ding, etc. (S	At home, farm, st specify)	reet, factory	, office		28	3f. Location (S City or Tox	Street and vn, State)	d Number or Run	al Route Nu	ımber,
	Hospital		29a. Certifier Certifyin	g Physician: To th	e hest of m	v knowledge dea	th occurred	at the tim	e. date an	d place, an	nd due to the	cause(s)	and manner as s	tated.	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical		Examiner: On the											o(s)
	To th within To th comp	Me	29b. Signature and title of certifie				2,00	License	number	> i		29d. Date	signed (Month)	Day, Year)	
$\wedge$	m							P	119	1/		_	11/10	6	
12			30 Name and Tollers of Asson	who completed car	se of death	(Item 23a) (Type	Print)	Ni	14/1	DF	T. M	7 hr	19100/	nD2	VX44
	Sta	ate	31. Date filed (Month, Day, Year)		Registrar's	Signature	J. J	100		٠ / د	, , , , ,				11/
	Registr	rar	MAY 1 2 2	006	we.	No April	20								

State of Maryland / Department of Health and Mental Hygiene For State Ragistra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Myrtle Sanford Betters 10, 2006 3:35 May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cheverly, MD

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Prince Georges Prince George's Hospital 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 87 Director 20, 1918Wash., NOV 577-22-5560 Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rei', or iteme 23a or 28a-f ehow Exeminer must be notified at 1 ☐ Yes 2 No P.G. Mitchellville Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20721 11503 Belvidere Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 □ Yes Z No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No 2.☐Widowed 4 ☐ Divorced Specify: ş Year or Dates: "neturet" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Jother then " Elementary/Secondary (0-12) College (1-4or 5+) Private Supervisor Guest Relations 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bessie Virginia Montague ဂ္ Rev. Henry Clinton Sanford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Joan Betters Butler-Daughter 1503 Belvidere Rd., Mitchellville, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition ¥⊠Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial May 17,2006 Suitland, MD eral Service Lacenses 21. Signature of Fu -22. Name and Address of Facility 1722 N. Capitol St., Taylor's Funeral HomeWashington, DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Acute Respiratory Distress Syndrome /Medical resulting in death) Due to (or as a consequence of) Examiner Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 TUnknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Ischemic Colitis 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Mopatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 ☐ Yes ANO 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: (XX) atural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide within 24 hours 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and tipe of certifier 29d. Date signed (Month, Dey, Year) 72261 May 10, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Richard MANOLIS n 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar 2 2006 MAY 1

		State of Maryland / Dep	partment of Health and I	Mental Hyg	iene 006	16387
8 8	á)	Decedent's Name (First, Middle, Last)		2. Date of Deat		3. Time of Death
Physic		Richard Edward Brawner		May 10.	Day Year 2006	1:40 a M
/Medi		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
Exami	lei	Southern Maryland Hospital	Clinton		Prince (	200000
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth	Prince (	
Funeral Director		579-56-8562 ^{1⊠M 2□F} 60 ^{Yrs.}	Months Days Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign
		Usual Residence of Decedent		sept.2/,	1945 Wasi	ington,D.C.
land		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
Mary f eh	ō	Maryland Prince Georges Suitla	nd			Yes 2□No
the 28a	90	10e. Street and Number	10f. Zip Code	10	0g. Citizen of What Co	ountry?
with	O	3517 Terrace Dr. Apt. A	20746			
eath	0				United Sta	
Her d	Š	Armed Forces?  1 Never Married 25 Married 1 Yes 25 No	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> </ol>	o Rican, etc.)	Black, Whit	
rs af	by Funeral Director	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2√2 No Specify:		Specify: B1	.ack
P r r	ed	15 Decedent's Education 16a Dec	cedent's Usual Occupation		16b. Kind of Business	/Industry
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If Z 12.13-0030 filed within 72 hours after death with the Maryland Hygiene. wher than "naturel", or iteme 23a or 28a-f ehow ant, the Mudical Exactionat be notified at	Ö	17. Father's Name (First, Middle, Last)		ne (First, Middle, M		
yiditid 2.12 build be filed with Mental Hygiene arked other tha attc event, men	0	Raymond Brawner, Sr.	Rache1	Washing	ton	
should be nd Mental marked c	2		iling Address (Street and Number or Ru			Zin Code)
ite, INIAI yidilid Z.1.Z.1.3-0030 s.1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 Is marked other than "naturel", or iteme 23s or 28s-1 show other treumatic event, the Middigal Exercipational be notified at			7 Terrace Dr. Apt.			20746
Heal Heal ther			position (Name of rematory or other place)		20c. Location - City or	Town, State
or or		I Dunai 2 Cremation 3 Chemoval nom State			Ť	
parmit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tree				10,2000	Suitland,	ria.
De De De De De De De De De De De De De D		21. Signature of Punetal Service Education	22 Name and Address of Facility Alexander S. Pope 5538 Mariboro Pik	Funeral	Homes, M.	Α.
- 40200		The way				
		23a. Part I. En The disease, or confolications that caused the death. Do not e show, or he in failure. List only one cause on each line.	inter the mode or dying, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	Infarction			Silver and Boain
/Medical Examiner		resulting in death)  Due to (or as a consequence of):	Failure			
LAdiffile	L	Sequentially list conditions, b. Respiratory	Tallure			
P ÷	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
ecute and trans	me	that initiated events				
e be executed sician and burial-transit	<u>G</u>	resulting in death) Last Due to (or as a consequence of):				
ate b hysic the b	Ilcai	d				
e as	Physician/Med	IF FEMALE:				
ath co	an/	23b. Was decedent pregnant in the past 12 months?	B Ectopic pregnancy		23d. Date of de Month	livery Day Year
e de the sad for	S	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)			24,
at the	Phy			100 0000		
es tr igne be d	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to	_
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as be	ple			24a. Was an autops	24b. Were au	utopsy findings available completion of cause of
The The	Completed			perform	ned? death?	2 □ No
rtifica	0	25. Was case referred to medical	26. Place of Dea	th (Check only one		
ysic ysic is ce direc	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpat	ent 3 DOA Other: 4 Nursing H	ome 5 Reside	nce 6 ☐Other (Spe	cify)
g Phy gerthi		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury		28d. Describe ho	w injury occurred	
ath. r: Afte	atio	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	M 1 Yes 2 No			
Afte de de by the by th	tiffe	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Str. City or Town	reet and Number or Ri	ural Route Number,
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pspit hour inera y fille		29a. Certifier 12 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place	, and due to the ca	use(s) and manner as	s stated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	rred at the time, da	ate and place, and due	to the cause(s)
within To th	M	29b. Signature and the of certifier	29c. License number		d. Date signed (Mont	h, Day, Year)
		▶ kk X a a	D0061415		5/10/06	
$(\mathcal{U})$		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)		,	
ノザ	10	Linich Gamblack Ad.D.	URRATTS RD. CLIN	מא אחי	20735	
St	ate	31. Date filed (Month, Day, Year) 2. Registrar's Signature		ه اللتا و المحد	<u></u>	
Regist	rar	MAY 1 2 2006	we			

			1 - For State Registrar	State of M	Marylan		artmen rtificate					Reg. No	ZUUD	16388
	Physic /Medi	cal	1. Decedent's Name (First, Middle,  Lessig  4a. Facility Name (If not institution,	auch	or)		4h City	Town or	Location	of Dooth	2. Date of Do Month	10 Da	Zon Ger County of Death	3. Time of Death
	Exami	ner	Bradford Oaks N	ursing Home		last birthdav)		Linto			8 Date of Bi		PG	place (State or Foreign
A	Funeral Director		241–32–7013 Usual Residence of Decedent	1 <b>⅓</b> M 2□F	77	Yrs.	Months	Days	Hours	Min.	8. Date of 8i (Month, Di 02/08/	1929 1929	N. C	Carolina
	e Marylan Ba-f ehow	ctor	MD PG		10c. City	y, Town or Lo Clint								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with th	al Directo	10e. Street and Number 10104 Cutters Ro	ow Court			10f. Zip	Code 2073	5			10g. Ci	tizen of What Coul USA	ntry?
036	should be filed within 72 hours after death with the Maryland of Menial Hygiene. marked other than "natural", or Itams 23a or 28a-f ehow imatic event, the Medical Extendent must be notified at	by Funeral	11. Marital Status  1 ☐ Never Ma <i>rt</i> ied 2 ☐ Married 3 ☐ Widowed 4 ★ Divorced	12. Was Deceder Armed Forces 1  Yes 2 If Yes, Give Year or Dates	s? ]No		Was Deced f Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto i	ecify Yes or No Rican, etc.)	0-	14. Race - Americ Black, White, Specify: Bla	etc.
1215-0036	within 72 ho ene. than *natur he Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0·12)		r 5+)	life. L	ent's Usua kind of wor DO NOT us cial	k done d e retired	fu <i>ri</i> ng most )		3		ind of Business/In	dustry
Maryland 21	e de fa	To Be Co	6th 17. Father's Name (First, Middle, La Jessie Beach, S						18. Mothe	r's Name	(First, Middle sa Dowe	, Maiden		
	1 and 2 s Health ar em 27 le ther trau		19a. Informant's Name/Relationship Barbara Jackson  20a. Method of Disposition				Cutt	ers	Row (	Court	Route Numb	ton,	MD. 20 ocation - City or To	735
galtimore,	permit. Pages Department of I Important: If it any injury or o once.		1	cify)		. Linc		emet	ery (	05/17	//2006	Bre	ntwood,	Maryland
	enysician		23a. Part 1: Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	molications that cause by one cause on each	ed the death line.	. Do not ente	er the mode	leve	land g, such as o	Aver	ue: Ri	verd	al Servi ale, MD	20737 Approximate Interval Between Onset and Death
	Certificate be executed ding physician and see as the burial-transit	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa Causa C	c	s a conseques a conseques									
Ď.	atter for u	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetel	death 3 🗌	Ectopic pre Other (spe				4 - March 2 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		23d. Date of delive Month	ory Day Year
cords, r	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions	contributing to death	but not resu	lting in the un	derlying ca	use give	n in Part I.		23e. Did to		se contribute to th	e cause of death?
nec.	The lay ate has page 2	Completed											24b. Were autop prior to con death? 1  Yes	osy findings available npletion of cause of 2 No
ion or vital	ra file	atlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Datural 5 Pending investigat	Hospital: 1 Inpat		ER/Outpatient 28b. Time of Injury		c. Injury Work	4 Nur	sing Hom	(Check only only only only only only only only	dence 6	3 ☐ Other (Specify occurred	)
DIVIS	lo the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Certification:	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of Ir	njury - At hor tc. (Specify)	me, farm, stre	et, factory,	office		2	Bf. Location (S City or Ton	Street and vn, State)	d Number or Rural	Route Number,
	the Hospi ain 24 hou the Funer apletely fill	ledical	one)	Physician: To the bes aminer: On the basis and manner s	of examinatii	rledge, death on and/or inv	estigation, i	in my opi	nion, death	l place, ai n occurre	nd due to the o	cause(s) date and	and manner as sta place, and due to	ated. the cause(s)
ı	con Town	×	29b. Signature and title of certifier	James	ノ~	1		License					signed (Month, E	
	5		30. Name and address of person wh	DUNER	des		rint) Living	poten	Ron	1 , F	at w	MAL	intrime	mylm/
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 2 2005	32. Regist	rar's Signatu	JI O	15							

			1 - State Registrar	State of Ma	aryland		artment of H tificate of		d Mental	Hygie	L. U	96	16389
	, ,		Decedent's Name (First, Middle, La	est)					2. Date	of Death			3. Time of Death
	Physicia		Lucy M. Bryan	a t					Mont		Day 2006	Year	1754 M
j	/Medic Examin		4a. Fecility Name (If not institution, gir				4b. City, Town, o	or Location of D		/,	4c. County	of Deeth	1754
		•	3800 Enfield Chas	se Court -	Apt.	104	Bowie				Princ	ce Ge	orge's
	Funeral		5. Social Security Number 6.3	Sex 7. Ag		ast birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date	of Birth		9. Birthp	lace (State or Foreign
ш	Director		577-05-9010	1□M 2XF	90	Yrs.	Months Days	Hours A	Min. (Mon. Apri		1916	Virg	inia
	pu ,		Usual Residence of Decedent										
	anyles ahow	_	10a. State 10b. County		10c. City	, Town or Lo	cation					11	0d. Inside City Limits
	Be-f	cto	Maryland Prince (	George's	Bow	ie							1 X Yes 2 □ No
	or 2	Dire	10e. Street and Number				10f. Zip Code			10g	. Citizen of V	Vhat Coun	try?
	23a	-E	3800 Enfield Chas				20716			U.	S.A.		
	tems	by Funeral Director	11. Marital Status	12. Was Decedent I Armed Forces?		5.   13. \	Vas Decedent of H f Yes, specify Cub	lispanic Origin' an, Mexican, P	? (Specify Yes uerto Rican, et	or No- c.)		e - Americ k, White,	
36	s afte	Ž	1 Never Married 2 Married 3 🖫 Widowed 4 □ Divorced	1 □ Yes 2 🛣 N If Yes, Give	lo		Yes 2∭ No	Specify:			Specify	T 71. 4	4
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15	in 72 n ne	Siet	(Specify only highest gr	ade completed)		(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of	working	10	b. Kind of Bu	siness/ind	lustry
212	filed within Hygiene.  Ther than "I ant, I've mus	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	House		,		0	wn Hon	ne.	
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an	lid be lenial ked c	To B	Robinson Marks					Dolie	Brown				
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	Hospitei 4 hours a Funerel I		29a. Certifier 1 X Certifying Pl	hysician: To the best of	of my know	riedge death	occurred at the tin	ne date and ol	ace, and due to	the caus	a/s) and mas	nor as eta	tod
	24 Fulletely	Medical	(Check only 2 Medical Examone)	miner: On the basis of and manner sta	examinati	on and/or inv	estigation, in my o	pinion, death o	ccurred at the t	ime, date	and place, a	nd due to	the cause(s)
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director:	Me	29b. Signature and title of certifier				29c. Licens	e number		29d.	Date signed	(Month, D	Pay, Year)
			1/6	le .			10-	3440	2	Ma	ay 8,	2006	
2	-(14)		30. Name and address of person who	completed cause of de	eath (Item	23a) (Type, I							
1_	<b>(</b> )		Andrew Scott Dobi		-		Hanson Co	ourt, S	uite 20	3A, 1	Bowie,	MD 2	20716
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	Registr	ar	MAY 1 0 200	U MORE	1	M							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2 Date of Death Decedent's Name (First, Middle, Last) 0 5 3. Time of Death 08% **Physician** Julian Hayes Bailey 2006 2:00 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Hospital Cheverly Prince Georges 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2 ☐ F 80 Yrs 123-18-5788 New York 05/31/1925 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 1 and 2 should be filed within 72 hours after death with the Marylar feath and Mental Hygiene. In 27 is marked other than "natural", or Items 23a or 28a-f show The fraumatic event, Ite Marylan Esta interment or recilitied ty Yes 2 No MD Prince Georges Funeral Director Mitchellville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number U.S.A. 20721 11411 Lake Arbor Way #317 Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. -Armed Forces? 1943 - Was Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Yes 2 No
If Yes, Give
Year or Dates: 1946 1 ☐ Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 2^{College (1-4or 5+)} Elementary/Secondary (0-12) Commisioner Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter Clifford Bailey Edith Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 7 2 1 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2. Department of Health at Important: if item 27 is eny injury or other traconce. 11411 Lake Arbor Way#317 Mitchellville, MD Marian C.Bailey/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State Riverdale Park Cem 05/11/06 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Taylor II Funeral Chapel 10583 Middleport Ln. White Plains, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINOMA LUNG **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events recurring in Jean ) Last Due to (or as a consequence of) Examiner the attending physician and ned for use as the burial-transit certificate be executed Due to (un as a consequence of). Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 1 Yes 25. Was case reterred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Injury at Work? After 1 Natural 2 ☐ Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide Ptace of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Chack only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D58182 9 Name and address of person who completed cause of death (Item 23a) (Type, Print) PV1 CHEVERLY MD 20185

DHMH 17 Rev 1/2001

State Registrar

DONALD

fited (Month, Day, Year)
Y 1 0 2006

HOSPITAL

3001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink

Earle R. Mason-Bey State of Maryland / Department of Health and Mental Hygiene 1. For State Amend#20b.PerFHPGC5-18-06Cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 28, 2006 **Medical Examiner** 0440 hrs <u> Earl Ricardo Mason Bey</u> 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Oxon Hill 3430 Brinkley Road Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of 8irth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Min. Months Days Hours November 8, Director 1 X M 2___F Yrs 555-63-8635 DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or items 23a or 28a-f show must be notified at once. Prince George Temple Hills 1 X Yes 2 No MD death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Americia 3430 Brinkley Road #204 20748 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Yes 2 **X** No imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after onen of Health and Mental Hygiene Yes, Give Year Black 3 Widowed 4 Divorced 1 Yes 2 X No specify: Specify: "natural" \$ Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Medical is marked other than Private Truck Driver 10th 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) æ Lenwood Sander <u>Helen Mason</u> ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) \$430 Brinkley Road, Temple Hills, Md. 20748 Wife If item 27 Jamie Harris / 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Baltimore, 8, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important: I Landover, Maryland National Harmony 2006 Donation 5 Other Specify 22. Name and Address of Facility 21 Signature of Funeral Service Licensee 4804 Murray Funeral Home NW Washington, DC 20011 Georgia Ave. Part I. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. 8etween Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease ≒xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examine Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ned by the a detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' certificate page ✓ Yes 2 No ✓ Yes 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: æ examiner? Other₄ DOA After this Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 🗸 Other. Scene ဂ္ 1 V Yes 28a. Date of Injury (Month, Day,Year) FOUND: 27, Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot FOUND: Natural Yes 2 V No 5 Pending death. in by the To the Funeral Director: Apr 28, 2006 0435 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 ___ Suicide Could not be 3430 Brinkley Road Apt 204, Oxon Hill, MD determined (Specify) Multi-Family Apt. 4 V Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) O.C.M.E. April 28, 2006 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 filed (Month, Day Year) 32. Registrar's Sign State 10

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<b>€</b>	Physic this c	မ	1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inp		ER/Outpatie			4 LI NUIS				6 ☐Other (Spec	ify)	
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	Physici		1. Decedent's Name (First, Middle, Last	Edward	CONFE	R	2. Date of Deat Month	Day 2006	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give  NoR+ Wes  5. Social Security Number  6. Se  215-18-7874  Usual Residence of Decedent	street and number) + HOSPi+c	last birthday) If Under 1 Y	en, or Location of Death  A A I S A  ear If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day, OC+, 13	Year) 9. Birthi	loke  place (State or Foreign  ntry)  ryland
	e Maryland ta-f ehow	ctor	10a. State 10b. County  MD Talba		y, Town or Location W; ++ Ma	ท			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If term 27 is marked other than "naturel", or iteme 23a or 28a-f show important: If term 27 is marked other than "saturel", or iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examinal must be notified at once.	by Funeral Director	10e. Street and Number  23346 C00  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 (P'49s, 2 () N 1/2 1 Yes, Give Year or Dates: 1/3 o/	.S. 13. Was Decedent If Yes, specify (	of Hispanic Origin? (Sp Cuban, Mexican, Puerto		Og. Citizen of What Cou  L S A  14. Race - Ameri Black, White,  Specify: R L	can Indian,
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ore, mary	ies 1 and 2 sho of Health and P if item 27 le me or other trauma		19a. Informant's Name/Relationship (T	Oper 20b. F	19b. Mailing Address (St. 9807- Plow Place of Disposition (Name cometery, crematory or other	line Road	d Randa	City or Town, State, Zip 2/15-10 W.N. / 20c. Location - City or To	MD.21133
	permit. Pag Department Important: I eny injury c		4 Donation 5 Other (Specify,  21. Signature of Funeral Service Licens	Ve	teran's Ceme 22. Name and Ar J HENRY	ddress of Facility Fune Ral	Home, P.	Hurlock,	MD.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a prenmo	h. Do not enter the mode of	Shing to August a cardiac	or respiratory arre	Abridge/	Approximate Interval Between Onset and Death
,000,	cate be executed hysicien and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq  Due to (or as a conseq  d.	uence of):	diseas	en te		
O. BOX O	The law requires that the death certificate ate hes been signed by the attending phys bage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3 □Ectopic pregn			23d. Date of delive	ery Day Year
r (Sp. D	equires that en signed b ould be deta	þ	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying cause	given in Part I.		acco use contribute to the	he cause of death?
מו שבני	rsician: The law r s certificate hes be lirector, page 2 sh	Completed						prior to co death? No 1 \sum Yes	psy findings available mpletion of cause of
2 2	hysicial his certii il directo	To Be	T Tes 2400	/ \	ER/Outpatient 3□ DOA	Other: 4 Nursing H	th <i>(Check only dne</i> ome 5 ☐ Reside	a) nce 6 □Other (Specif	iy)
	tending P	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	М	njury at Work? 1 ∐ Yes 2 ∐ No	28d. Describe ho		
2	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		4 Homicide determined	building, etc. (Specification: To the best of my known			City or Town		
	thin 24 ho thin 24 ho the Fun mpletely	Medical	(Check only 2 Medical Examone)  29b. Signature and title of certifier	iner: On the basis of examina and manner stated.	tion and/or investigation, in r	ny opinion, death occur	red at the time, da	te and place, and due to	the cause(s)
	Vait To Con		1 Again	ms	$\mathcal{L}$	43977	<u>'</u>	nay 6.	2006
			30. Name and address of person who co	ompleted cause of death (Iten	Dome lile	n Bunie	, rus.	2/06/	
	Sta Registr			2006	H Should				

			1 - For State Registrar	State of M	laryland		artmen <i>rtificat</i>			nd M		giene Reg. No.	200	5 1	6395
D.	Physici	an	1. Decedent's Name (First, Middle, La	•		-					2. Date of De Month	Day	Yea		Time of Death
	/Medic		Elizabeth R. C								May	7,	200	6 19	00 PM ^M
	Examin	er	4a. Facility Name (If not institution, giv		7)				Location of	Death			ounty of D		
- 7		373	Prince George Ho  5. Social Security Number 6. S		ige (In yrs. la	ast birthday)	If Under	ever	Ly If Under 2	4 Hrs.	8. Date of Bir		nce G		State or Foreign
	<ul> <li>✓ Funeral</li> <li>Marie Director</li> </ul>			□M 25€1F	79	Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year)		Country)	State or Foreign
	P .		Usual Residence of Decedent		7							,			
	arylar ehow	5	10a. State 10b. County DC •		-	, Town or Lo lashing		рс							side City Limits XYes 2 ☐ No
	Ne M.	Director	10e. Street and Number			asiiiii	10f. Zip		•			10- 04-	on of What		2.765 2 1.10
	with	급	4028 E Street, S	F			TOI. ZIP		0019			•	ted S	,	
	ne 23	era	11. Marital Status	12. Was Deceden		6. 13. \	Was Deced			in? (Spec	cify Yes or No Rican, etc.)			merican Ind	lian,
36	be filed within 72 hours after death with the Maryland that Hygiene.  Id other than "neturel", or iteme 23e or 28e-1 ehow event, the Markleal Expiditer must be multiped at	by Funeral I	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give	] No	ř	fYes,speo 1□Yes :		Specify:	Puerto F	Rican, etc.)		Black, W	hite, etc. Black	ζ
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nd	be filed tal Hygi d other	Be	17. Father's Name (First, Middle, Last,								(First, Middle		umame)		
yla	2 should be to and Mental I is marked or raumatic eve	7	Fred Washington								e Stewa				
Baltimore, Maryland	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship ( Carolyn E. Graham								Route Numb hington			a, Zip Code, 019	)
ore,	m O		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		60	ace of Dispo metery, cren	sition (Nan	ne of ther place	,)	Da	ate	20c. Loca	tion - City	or Town, St	tate
ш	Pages ment of I ant: if its ury or o		4 □ Donation 5 □ Other (Specif		Harn	nony M	emori	al P	arkMa	•			over,		
Balt	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Lice	Mike	elf	22	. Name an	d Address	s of Facility	Po: 55. Fo:	pe Fune 38 Mar restvi	eral l lboro lle, l	Homes Pike MD.	20747	
2	* # **		23a. Part1. Enter the disease of com shock, or heart failure. List only	plications that cause one cause on each	ed the death. line.	. Do not ente	er the mod	e of dying	, such as c					Appro	oximate val Between
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	/Medical Examiner		resulting in death)	Due to (or as a consequence of):											
	LAdilline	er	Sequentially list conditions,	b. Due to lor a	s a cons	once of:									
	ted nsit	nine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for a	s a consequi	erice orj.									
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9	tificat ng phy as th	ledi	15 55 W. 5												
Box	eath certific attending p for use as	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1☐Live birth			Ectopic pr	egnancy				23	d. Date of		Wass
В	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐XNo 9 ☐ Unknown	4□Pregnant : 9□ Unknown	at time of dea		Other (sp.			-			Month	Day	Year
<b>a</b>	that the ed by detac		Part II. Other significant conditions of	ontributing to death	but not resul	Iting in the ur	nderlying ca	ause give	n in Part I.		23e. Did t	obacco use	contribute	to the caus	se of death?
rds	quires n sign	d by	Chronic Obstru	ctive pul	monary	dise	ase				10	Yes 2 🗆	No 3⊠	Probably	4 Unknown
Division of Vital Records,	The law requires that ite has been signed b age 2 should be deta	Completed	Hypertension								24a. Was	an	24b. Were	autopsy fin	idings available
R	The lavate has	mo:	Ostroarthritis									ormed?	death		on of cause of
ita	ysician: is certifica director, p	ВеС	25. Was case referred to medical examiner?						26. Place o	of Death	(Check only o				
) t	dis y	ဥ	1 ☐ Yes 2 🔀 No	Hospital: 1 Inpat		R/Outpatien			T LI ITUIS		ne 5 ☐ Resid			oecify)	
ou c		lon:	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of In (Month, D	ay Year)	28b. Time of Injury	M 2	8c. Injury Work	at ? es 2 ∐ N		8d. Describe I	how injury	occurred		
isio	deal deal ctor: y the	licat	2 Accident investigation 3 Suicide 6 Could not b		niury - At hor	ne, farm, stre			65 2 11		8f. Location (S	Street and I	Number or	Rural Route	e Number
Ξ	in Direct	Certification:	4 Homicide determined	28e. Place of In building, e	etc. (Specify)	)		,			City or Tox			, , , , , , , , , , , , , , , , , , , ,	J. 12.11.20.1
	10ep	edical	29a. Certifier   1 Certifying Ph (Check only one)   2 Medical Exam	ysician: To the bes niner: On the basis and manners	of examination	vledge, death on and/or inv	occurred a restigation,	in my op	e, date and inion, death	place, ai occurre	nd due to the d at the time,	cause(s) ar date and p	nd manner lace, and d	as stated. ue to the ca	ause(s)
	To the within 2-	Ž	29b. Signature and title of certifier				290	. License	number			29d. Date :	signed (Mo	nth, Day, Y	'ear)
			Tolu pose	76300 0	w			21.	240	DO		05	10/	200	9
R	(')		30. Name and address of person who	/	•				- al- 2	- de -	DC	2000	,		
1	Sta	te	Edsel J. Gayoso, 31. Date filed (Month, Day, Year)		th CAp		st. N	w; Wa	asnin(	glon	, вс.	20002	<u> </u>	<del></del>	
	Registr	- 2	MAY 1 2 200		, K	Sie	2								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene 2000

		1	= For State Registrar	State of Man		tificate of L		f	Reg. No.	UUU	10390
	Physicia	_	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al -	ELIZABETH REARDON			# C' T-	1	May 5,		ty of Deeth	7:40 p M
	Examin	er	4e. Fecility Name (If not institution, give s	treet and number)			Location of Death			•	rge's
			6020 43rd Avenue  5. Social Security Number 6. Sex	7. Age (	n yrs. last birthday)	Hyattsvi If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	_		place (State or Foreign
H	Funeral Director			M 2 <b>X</b> ) F	32 Yrs.	Months Days	Hours Min.	Aug. 5,	1923		sylvania
000	show Lat		10a. State 10b. County	11	Oc. City, Town or Lo					1	10d. Inside City Limits
7	8a-1 s	Director	Maryland Prince G	eorge's	Hyattsvil				10g. Citizen of	Mar Cou	
40,000	3a or 2	i Dir	10e. Street and Number 6020 43rd Avenue			10f. Zip Code 20781			U.S.A.		nuy:
0	ma 2	ner		2. Was Decedent Eve Armed Forces?	er in U.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Americack, White,	
2	ges 1 and 2 should be filed within 7.2 hours after beant with the maryaning file of Health and Mental Hygiene. It of Health and Mental Hygiene. Or other traumatic event, it a Medical Exactinar must be routified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	i	I□Yes 2X No	Specify:		Spec	ity: Wh	ite
	natur	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	lent's Usual Occupa	luring most of work	ing	16b. Kind of		
7	Man and and and and and and and and and a	app.	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired			Archdi Washin		e of
7	tygier her ti		12 17. Father's Name (First, Middle, Last)		Admin	istrative	18. Mother's Nam				
	ntal hed of	Be	Robert Reardon				Violet				
	should and Men s marke umatic	2	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	ng Address (Street a			r, City or Town	n, State, Zip	Code)
2 3	Ith and 2 S		Lynn A. Cotturo -		6020	43rd Av	enue, Hy	attsvil	le. Mar	vland	20781
ก์ .	item other		20a. Method of Disposition		20b. Place of Dispo cemetery, cren			Date	20c. Location		
<b>E</b> ,	Pege Tento Try or		1 \ Burial 2\ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	Gate of H	Heaven Cer	metery 5/1				ng, Maryland
Danimor	permit. Peges 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		21. Signature of Juneral Syrvice1 icepas	Heat		Name and Addres				-	
	40244		23a. Part1. Enter the disease, or compli	ations that caused th						, 115	Approximate Interval Between
	Mariatan		/shpck, or heart failure. List only on Immediate Cause (Final	e cause on each line.							Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a c	a consequence of):						10 Years
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury)	Due to (or as a o	consequence of):						
	outed Id ransit	Examiner									
68760,	ficate be executed physicien and is the burial-transit	icai Ex	resulting in death) Last	Due to (or as a o	consequence of):					4	
	ficate p phys	edic									
O. Box	es that the death certi igned by the attending be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				ate of deliv Month	ery Day Year
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rds	w requires been sign should be	ed by						1 🔯 `	Yes 2□No	3 🗌 Prol	bably 4 □Unknown
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IIa	ysician: ils certifica director, p	Be	25. Was case referred to medical examiner?			100	26. Place of Dea	th (Check only o	nne)		
0	Physician: r this certific ral director,	2	1 ☐ Yes 2 🛣 No	lospital: 1   Inpatient			4 🗆 Nulsally Fi	ome 5 X Resi			(y)
ono	ding h. Atte	ation:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day)	(ear) 28b. Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe	now injury occi	urrea	
<u>-</u>	l or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	reet, factory, office		28f. Location ( City or To	Street and Nun vn, State)	nber or Run	al Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Directompletely filled in by	edical C	29a. Certifier 1X Certifying Physical (Check only one)	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	h occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	and due to the rred at the time,	cause(s) and r date and place	manner as s e, and due t	stated. to the cause(s)
	within 2 To the complet	Med	29b. Signature and title of certifier	A /	0	29c. Licens	e <i>n</i> umber		29d. Date sign	ned (Month,	Day, Year)
^			Muchail	Den	and, m		6287		May 8	2006	5
4			30. Name and address of person who co	D 7305 B	altimore	Ave., #10	7, Colle	ge Park	, Maryl	and 2	0740
	St Regist	ate	31. Date filed (Month, Day, Year)  MAY 1 0 2006	2. Registrar	s Signature	Les .					
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	Dhuaisi		1. Decedent's Name (First, Middle	e, Last)						2.	Date of De. Month	ath Day	Year	3. Time of Death
1.00	Physici /Medio		Doris	E Ch	ambers	3				Ma	ay 9,			9:05 p M
	Examir		4a. Facility Name (If not institution		,		4b. City, To	own, or	Location o	of Death		4c.	County of Deat	h
		* 18	Calvert County							erick			Calvert	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs.		If Under 1 Months	Year Days	If Under :	Min.	Date of Birt (Month, Da	y, Year)	9. Birti Co	hplace (State or Foreign untry)
	Director		311–32–0321	الهرد الله	74	Yrs.				A	ug. 2	4, 19	931 Pen	nsylvania
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	Mary!	٥	MD Calv	ort		Dur	kirk							1 ☐ Yes 2 🕅 No
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336	al', or	by	3 Widowed 4 Divorced	If Yes, Gir Year or D	ve		1 ☐ Yes 2	No D	Specify:				Specify:	white
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b	otho Vent	Be C	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name <i>(F</i>	irst, Middle,	Maiden .	Sumame)	
la	Aents Aents rked	70 E	Clayton E	eland					Ha	azel		unob	tainabl	e
Maryland	and l		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (	Street a	nd Numbe	or Rural A	oute Numbe	er, City or	Town, State, Z	lip Code)
Z	and selth		Roy Chambers, J	r., husba		3352	Lyons	Cre	ek Ro	i., Du	nkirk	, MD	20754	
<u>S</u>	of He	-	20a. Method of Disposition  1 Darrial 2 Deremation	2 (18	1 0	lace of Dispo emetery, crei	sition (Name	of .	1	Date			cation - City or	Town, State
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Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Service	Ligensee		22	. Name and	Address	s ol Facility	У			•	
m	89 = 9		Duya!	M/ Yes	bach	, Ra	usch I	'une	ral H	lone,	P.A.,	Owi	ngs, MD	20736
$\mathbb{Z}_{\lambda}$			23a. Part I. Enter the disease, or shock, or heart fallure. List	complications that only one cluse on e	aused the death	h. Do not ent	er the mode	of dying	, such as	cardiac or re	espiratory ar	rest,		Approximate Interval Between
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	/Medical		resulting in death)		(or as a consequ		RUCE,	-1-0			21	04.10	Ç	TENKS
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'ita	Physician: r this certific ral director,	Be (	25. Was case referred to medica examiner?						26. Place	of Death (C	heck only o	ne)		
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ם	ding P h. After t funera	ü	27. Manner of Death 1 ☑Natural 5 ☐ Pendin	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	280	. Injury Work	at ?	280	l. Describe h	now injury	occurred	
Si.	Attending r death. ector: After by the fune	cati	2 Accident investi	gation			М		'es 2 □ N					
Division	or Att	Certification:	3 Suicide 6 Could 4 Homicide determ	ined   286. Place	of Injury - At ho ing, etc. (Specify	ome, farm, str v)	eet, lactory,	office		28f.	Location (S City or Tox	Street and vn. State)	Number or Ru	rai Route Number,
0	ral D													
	Hosp 4 hou Fune ely fii	icai	(Check only 2   Medical	ng Physician: To the Examiner: On the b	asis of examinat	wledge, death tion and/or in	n occurred at vestigation, in	the time	e, date and inion, deat	d place, and th occurred	due to the dat the time, d	cause(s) a	and manner as place, and due	stated. to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	one)  29b. Signature/and title of certifie	and man	ner stated.				number					
	Twi So	-	230. Signature and title or certifie	2000	44.0							/	signed (Month	, vay, 18a1)
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	ŋ		30. Name and address of person					_						
(3)	0		Peter L. Wis 31. Date liled (Month, Day, Year)	niewski, M	M.D., 11	10 Hosp	pital :	Rd.	Suit	e_310	, Prin	ice F	rederic	k, MD 20678
	Sta Regist		Peter L. Wis: 31. Date liled (Month, Day, Year) MAY	1 7 2nns	Care .	K	Local	20						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month MAY Day 4 MARGARET J. COOK 2006 10:45AMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TALBOT HOSPICE HOUSE EASTON TALBOT If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye SEPT. 15 Birthplace (State or Foreign Country) **Funeral** Months Days Year) 1 ☐ M 2 🕱 F Hours Min. Yrs 87 1918 Director 142-09-8402 PA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location works 10d. Inside City Limits r then "naturel", or Items 23a or 28e-f show the Medical Exercises must be rediffed at Yes 2 No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 708 WAYSIDE AVE. 21601 IISA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: WHITE ģ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within 7. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "ne eny injury or other treumatic event, the Media once. Elementary/Secondary (0-12) SECRETARY INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY MCCORMICK ပ္ FLORENCE EVANS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUSSELL H. COOK, JR./SON 4906 DAWSON'S WAY, ELLICOTT CITY, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 5/5/2006 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Useph 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Privsician disease Slavs icui /Medical to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 2 XNo 1 Yes 2 No Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 1 Tes this HOSPICE 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28d. Describe how injury occurred Certification: Hospital or Attending Injury 1 Natural 2 Accident 5 Pending death. 1 Tyes 2 No investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide 24 hours a 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Termying mystcian: To the best of my knowledge, death occurred at the time, value and place, and due to the cause(s) and manner stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29b. Signatur and title of cert 29c. License number 29d. Date signed (Month, Day, Year) al 30. Name and address of Jerson who completed cause Jath (Item 23a) (Type, Print) CAROLYN R. HELMLY M.D. 508 IDLEWILD 31. Date filed (Month, UNIXA) AVE., EASTON, MD 21601 Day, Year) Registrar's Signature State 0 8 2006 Registrar

			1 - For Stata Registrar	State of M		d / Depa		Health and M	Mental Hygi	•	15399
3	hysici	an	Decedent's Name (First, Middle,	Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Margaret L	ouise	Crane	2			May 14,	2006	6:00 a.m.
. S. E	Examin	er	4a. Facility Name (If not institution,	give street and number	)		4b. City, Town,	or Location of Death	1	4c. County of Deatl	1
K	.4	¥	22680 Cedar Lan					onardtown	_	St. Ma	
	ineral rector		217-22-7774	. Sex 7. A	ge (In yrs. I 96	ast birthday) Yrs.	If Under 1 Yea Months Day:		8. Date of Birth (Month, Day, Aug. 8,	(ear) 9. Birth Co. Virg	nplace (State or Foreign untry) Sinia
land	MOI		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
e Man	Ba-f sh	Director		Mary's			Leonardt				1 XYes 2 No
ith th	or 2	Dire	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Co	untry?
ath w	23		22680 Cedar Lan					0650		United S	
ar de	le m	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	S. 13.	Was Decedent of f Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White	
L L L I STOUGO filled within 72 hours after death with the Maryland Hygiene.	"natural", or Itema 23a or 28a-f show otical Extended court be notified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Married 4 ☐ Divorced	1 ☐ Yes 2X☐ If Yes, Give Year or Dates:	INO		1 ☐ Yes 2 ☐XN	o Specify:		Specify: Wh	nite
72 hg	"natu	Completed by	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced (Give	dent's Usual Occi	upation e during most of wori red)	king	6b. Kind of Business/I	ndustry
within iene.	rthan Its Ma	mp	Elementary/Secondary (0-12)	College (1-4or	5+)					Chata Cara	
filled v Hygie	ither.		17. Father's Name (First, Middle, La			Adııı	inistrat	ive Assis	tant ne (First, Middle, Ma	State Gove	ernment
ta la	p à	o Be	Robert P. Morga					Unkno		acon Gumame,	
		ပ္	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Stree		THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE S	City or Town, State, Z	in Code)
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/Me	sician edical miner		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	omplications that cause by one cause on each l a Due to (or as	SOF	Do not ent	er the mode of dy	ying, such is cardiac Failure An Don	or respiratory arres	t,	Approximate Interval Between One at and Death
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le be executed	ysician and he burial-transit	cai Exa	resulting in death) Last	c. Due to (or as	s a consequ	iance of):	rosol	Perose	J.		4X
tifical	as th	ledi	In FERMINE		0					11111	
To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after deeth.	signed by the attending phy d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pregnan Other (specify)	су		23d. Date of delin Month	Pery Day Year
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during .	on sign								1 ☐ Yes	2 <b>( N</b> o 3 □ Pro	bably 4 □Unknown
2 8	as been s 2 should	Completed							24a. Was an	24b. Were aut	opsy findings available
F ed .	certificate has rector, page 2	E O							autopsy	d? death?	ompletion of cause of
	tifica tor. p	0	25. Was case referred to medical		W = W			26 Place of Deal	1 ☐ Yes 2 € th Check only one	PNo (L) Yes	2 No
ysici		To B	examiner? 1 🗌 Yes 2 🗐 No	Hospital:	ient 2 🗆 f	ER/Outpatien	t 3 DOA O	Maria and		ce 6 □Other (Spec	(fv)
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를 를 를 .	e fu	atio	1   Natural 5 ☐ Pending 2 ☐ Accident investigat		ay / oa//	iii)ui <b>y</b>		Yes 2 No			
al or Atte	il Directo id in by th	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	286. Place of in	ijury - At ho tc. (Specify	me, farm, str	eet, factory, office	9	28f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,
To the Hospital or Attending Physicities 24 hours after deeth.	To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best aminar: On the basis of and manner st	of examinat	wledge, death ion and/or inv	n occurred at the restigation, in my	time, date and place, opinion, death occur	and due to the cau red at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
To the	COM	Ž	29b. Signature and title of certifier	01		11 1	29c. Licer	nse number	290	. Date signed (Month	
			h la	mas T. la	WOE	=/4/	JD	0041	/	5-16-	06
			30. Name and address of person wi	o completed cause of	death (Item	23а) (Туре,	Print)			· · · · · · · · · · · · · · · · · · ·	
	-2		James P. Jarboe	M.D. 124	035 T	hree N	otch Roa	ad, Hollyw	ood, Mary	land 20636	5
	Sta Registr		31. Date filed (Month, May X car)	7 2006 ^{32/R}	trar's Signat	ure	house				

			For State Registrar	State of Ma	ıryland		artment of F rtificate of		nd Mental H	ygiene Reg. No	400	5	6400
	Physici		Decedent's Name (First, Middle, Last)     Robert	М.	Coo	1			2. Date of I Month May 8	Dat	56 Yes	3.	Time of Deathp 8:00 M
	/Medic Examin		4a. Fecility Name (If not institution, give str	reet and number)			4b. City, Town, o	r Location of	Death	4c.	County of D	eath	
1		H	609 Bowman Drive	1	//		Sali	sbury	4 Hrs. To Day 1/5		Wico		(6)
d	Funeral Director		5. Social Security Number 6. Sex 1219–46–2682		i (in yrs. ia 59	st birthday) Yrs.	Months Days	Hours	Min. 8. Date of E (Month, I 8/19/	1946	D. D.	Country) elawa	(State or Foreign
	put &		Usuel Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d. I	Inside City Limits
	Maryla f sho	ŏ	Maryland Wicomic	0		lisbu							1 ☐ Yes 2 ☐ <b>(</b> No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What	Country?	
	ath wit		609 Bowman Drive				218			1	SA		
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene is marked other than "natural", or Items 23e or 28e-f show aumatic avent, the Medical Exacular market notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	<ol> <li>Was Decedent E Armed Forces?</li> <li>1 XYes 2 N If Yes, Give Year or Dates:</li> </ol>			Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 ☑ No	lispanic Origii an, Mexican, i Specify:	n? (Specify Yes or I Puerto Rican, etc.)	10-	14. Race - A Black, W Specify:		
Š	72 hou	eted	15. Decedent's Educa (Specify only highest grade		Î		tent's Usual Occup		of working	16b. K	nd of Busine	ss/Industr	ry
21215-0036	within and the Men	Completed by	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. I	ntory Mar	d)	g	Dro	esser :	Tndu	stries
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/lan	should be ind Mental marked o	To B	Frank W. Cool					Jean	n Mcart				
Maryland			19a. Informant's Name/Relationship (Type	e, Print)			-		or Rural Route Num			e, Zip Cod	de)
	is 1 and of Health item 27 other tr		Vicki Cool/wife  20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of		Salisbury, Date	-	cation - City	or Town,	State
Ē	m O		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei 1 ☐ Donation 5 ☐ Other (Specify)	moval from State			natory or other place y Cremato	٠ .	5/9/06	Sa	lisbur	v, MI	)
Baltimore,	permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service License	leurs.	CEST	-	The second second second second second		al Home Pr Rd., Salis	_			
ě	Physician /Medical		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that gaused cause on each lin	Tant	ton	er the mode, of dyir	ng, such as ca	ardiac or respiratory	arrest,		Inte	proximate erval Between set and Death
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, 20,	cate be executed physicien and the burial-transit	i Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):				****			
98760	ficate t physics the b	edicai	d.										
O. Box	The law requires that the death certific ite has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of 1□Live birth 2 4□Pregnant at 1 9□Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify) _	1			23d. Date of o Month	delivery Day	Year
٦.	luires that the signed by ald be detacted	þ	Part II. Other significant conditions contr	ibuting to death bu	t not resul	lting in the ur	nderlying cause giv	en in Part I.		tobacco u		to the ca	ause of death?
Vital Records,		Completed							24a. Wa aut per 1 🗆 Yes	s an opsy formed? 2 No	24b. Were prior to death	o complet?	findings available tion of cause of
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Division	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc.	ry - At hon . (Specify)	ne, farm, str	eet, factory, office		28f. Location City or T	(Street an own, State		Rural Roi	ute Number,
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			1 For State Registrar	State of M	arylan	•	artment of I tificate of		and M	, ,	iene _{eg. No.} 2	006	16401
	Physici		Decedent's Name (First, Middle, Last     Ira Michae		n					2. Date of Deal Month	Day	Year 06	3. Time of Death 1638 M
i	/Medio Examir		4a. Facility Name (If not institution, give			WATE	4b. City, Town, o	or Location o		_	4c. Cou	nty of Death	
	Funeral Director		5. Social Security Number 6. Se 213-46-3535	x 7. Ag		ast birthday) Yrs.	If Under 1 Year Months Days		24 Mrs. Min.	8. Date of Birth (Month, Day, 4/3/194	Year)	Cour	place (State or Foreign ontry) cyland
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Somerse	t		rinces	cation ss Anne					1	10d. Inside City Limits 1 ☐ Yes 2X No
	h with the	Funeral Director	10e. Street and Number 28586 Mt. Vernon I	Road			10f. Zip Code 218	353		1	0g. Citizen USA	of What Cour	ntry?
036	perrilt. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 le marked other than "natural", or Items 23e or 28e-f ehow any njury or other treumatic event, the Medical Examiner must be notified at once.	Ď	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Wivorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	,	i i	Vas Decedent of I I Yes, specify Cub	an, Mexican	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)	E	Race - Americ Black, White, cify: Wh	
21215-0036	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or :	5+)	(Give life. L	lent's Usual Occup kind of work done DO NOT use retire	during most d)	of workin	ng		Business/In	
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	and 2 sho ealth and I n 27 le mu		19a. Informant's Name/Relationship (Ty Charles Wrightson,				g Address (Street 32 Mt. Ve						
Baltimore,	Pages 1 ment of He ant: If Iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	CE	emetery, cren	sition (Name of natory or other pla Cremato		5/15/			n-City or To bury,	
Ball	Departi Importa any nji		21. Signature of Funeral Service Coens  16.48 R V24	ney CE	Sp		SOT Show	HITT	Ra.,	Salisk	ury,	onal A MD 218	ssociation 804
ł	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	ne.	dire	infar the mode of dyi	ction			est,		Approximate Interval Between Onset and Death
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O. Box 6	ath certif ttending or use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	/				Date of delive	ory Day Year
rds, P	n requires that the de been signed by the e should be detached f	Ď	Part II. Other significant conditions con	ntributing to death b	ut not resu	lting in the un	derlying cause giv	en in Part I.			acco use co		e cause of death?
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Ĭ	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:			all post oth			Check only one			
on of	fing After fune	tlon: To	27. Manns of Death  1 atural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		ER/Outpatient 28b. Time of Injury	28c. Injur	4 LI NUT	28	e 5 Resider			')
Divisi	P S S S	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At hos c. (Specify	me, farm, stre				Bf. Location (Str. City or Town,	eet and Nur State)	mber or Rurai	l Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier (Check ord) 2 Medical Examinations)	sician: To the best ner. On the basis of and manner sta	i examinati	vledge, death ion and/or inv	occurred at the tirestigation, in my o	ne, date and pinion, death	place, ar occurred	nd due to the ca d at the time, da	use(s) and r te and place	manner as sta e, and due to	ated. the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifler	5			29c. Licens	21-	183	2	d. Date sign	ned (Month, L	Pay, Year)
	00		30. Name and address a person who co	nerton	, m	0 6	Print)	SAL	ICB	sury	ms	- 20	801
	Sta Registr		31. Date filed (Month, Day/Year)  MAY 1 6 2	32. Registra	ar's Signat	ure	1 4.			,			

		-	For State Registrar	State of Ma	ryland				ealth a Death	ind M	ental Hy	gier Reg. N	Z U U 0	16402
15	y * 1	*	1. Decedent's Name (First, Middle, Last	)							2. Date of D			3. Time of Death
ik.)	Physici /Medic	al	4a. Facility Name (If not institution, give	James Don	minic	Coyl			Location o	f Death	Month May 1	8,	2006  County of Dea	3:30 A M
	Examin	er								Douth				
			14623 Pennersville 5. Social Security Number 6. Se		(In vrs. la	st birthday)		asca 1 Year	If Under 2	24 Hrs.	8. Date of Bi	rth		ngton
	Funeral Director		220-16-0889	<b>X</b> M 2□ F	81	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D Januar	ау, Yea <b>у</b> 1	n1925 c	rthplace (State or Foreign ountry) Maryland
	and *	-	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	eho	5		,	•			_						1 ☐ Yes 2X No
	Ne N	Directo	Maryland Washin  10e. Street and Number	gton			10f. Zip	cade				10g (	Citizen of What C	ountry?
	with I	급					101. 21					rog. (	JIIIZGIT OF TYTIAL O	outiny :
	s 23	Funeral	14623 Pennersvill	e Road 12. Was Decedent E	vor in LLS	12 \	Nac Deco		719	nin2 (Sne	cify Yes or N	0=	U.S.A 14. Race - Am	
	er de Item	n	11. Marital Status  1 Never Married 2 Married	Armed Forces?		).   13. j	Yes, spe	cify Cuba	n, Mexican	Puerto !	cify Yes or N Rican, etc.)	0-	Black, Wh	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "naturel", or Items 23e or 28e-f ehow entry injury or other traumatic event, the Modical Erecular matche mailfied at once.	by F	3 XWidowed 4 Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2 <b>2</b> No	Specify:				Specify:	White
ŏ	2 hou	pe	15. Decedent's Edu	cation		16a. Deced	ient's Usua	al Occupa	ation	4		16b.	Kind of Business	s/Industry
72	n n	Completed	(Specify only highest grad	College (1-4or 5+	-)	lite. L	DO NOT u	nx done d se retired	during most ()	OF WOTKIE	ig			
7	d with	E O	8				Mach	anic					Auto	
g	be filed ntal Hygid od other	Be (	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	, Maid	en Sumame)	
<u>a</u>	should b and Menti marked umatice	2	James Dominic Co	yle, Sr.					Be.	rtha	Irene	Bot	vman	
Maryland 21215-0036	2 sho and le me	1	19a. Informant's Name/Relationship (T	ype, Print)		19b. Mailir	ng Address	(Street a	an <i>d Numbe</i>	r or Rura	Route Numi	per, City	or Town, State,	Zip Code)
	and 3 aalth n 27 ler tr		Jeffrey A. Coyle	(Son)	,								ryland 2	
e C	of He	1	20a. Method of Disposition 1 ☐ Burial 2 🗹 Cremation 3 ☐ I	Removal from State	20b. Pla	ace of Dispo metery, cren	sition (Nai natory or c	ne of ther plac	e)	May	21.	20c.	Location - City o	r Town, State
<u>Ĕ</u>	Pages nent of ent: If It ury or o		4 Donation 5 Other (Specify,		Smi	thsbur	g Cr	emat	ory	200	26			, Maryland
Baltimore,	permit. Departr Import. eny inj.		21. Signature of Funeral Service Licens	600					s of Facility					eral Home
<u> </u>	89 E 2 9		Jo Pice of	Davis /	1014	17							g, Mary	land 21783
j	Physician /Medical Examiner		25a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a	~ 1.	trolq	er the mod	S U	g, such as	cardiac o	r respiratory	arrest,		Approximate Interval Between Onset and Death
,0,		Examiner	S - juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a										
.O. Box 68760,	death certifical e attending phi of for use as th	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal	death 3	Ectopic p Other (sp						23d. Date of de Month	elivery . Day Year
<u>α</u>	quires that n signed b uld be dete		Part II. Other significant conditions co	ontnbuting to death bu	t not resul	lting in the u	nderlying o	ause give	en in Part I.					to the cause of death?  Probably 4 Unknown
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ita	icien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?							of Death	(Check only			
	Physicien: this certific ral director,	10	1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 🗆 E	P/Outpatier	nt 3□ D0	Oth	er: 4 🗆 Nu	rsing Hor	ne 5 Hes	idence	6 ☐Other (Sp.	ecify)
Division of	Attending PI ir death. ector: After th by the funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	f M	28c. Injury Work 1 🔲 '	yat k? Yes 2⊡!		28d. Describe	how in	lury occurred	
Divis	i di di	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At hor (Specify)	me, farm, str )	eet, factor	y, office		2	28f. Location City or To			Rural Route Number,
	e Hospitel 24 hours a e Funerel l letely filled	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	rsician: To the best o iner: On the basis of and manner stat	examinati	vledge, deatl ion and/or in	h occurred vestigation	at the tin	ne, date an pinion, deal	d place, a th occurre	and due to the ed at the time	cause , date a	(s) and manner a and place, and du	is stated. le to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	/	,		29	c. Licenso	e number			29d. I	Date signed (Mor	nth, Day, Year)
	-		1/00000000	11 1	- 1	In	5	12	36	73		~	an 1 G	2006
			30. Name and address of person who	completed cause of de	ath (Item	23а) (Туре,	Print)		,		!	~	11.	
	18		Frederici+ K	ASS III V	^^	IIII	m	de	ul (	er	Las	a	Liter	ex tun
Spanner of the second	Sta Regist	ate rar	S1. Date filed (Month, Day, Year)  MAY 2 4 2006	32. Registra	s Signati	Local	0							me

Denise Arlene Carlson

## Please Type or Print in Black Indelible Ink

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State of Maryland /	Department of Health and Mental Hygiene

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Physici Medical Exami		1. Decedent's Name (First, Middle,Last)  Denise Arlene Carlson		2. Date of Death Month May 3, 200	Day Year	3. Time of Death 1850 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death	
, ,		406 Mallard Road	Greensboro	lo o	Caroline	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. I	last birthday)  If Under 1 Year If Under 24Hi Months Days Hours Mi  Yrs.	_	Foreig	hplace (State or n untry) MN
any		Usual Residence of Decedent  10a. State 10b. County 10c. City,	, Town or Location			10d. Inside City Limits
	ō	Maryland Caroline Gree	ensboro			1 X Yes 2 No
Maryland r 28a-f she ed at once	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Coun	itry?
vith the	eral D	406 Mallard Road  11. Marital Status   12. Was Decedent Ever in U	21639  13. Was Decedent of Hispanic Origin? ( §	Specify Yes or No-	U.S.A.	can Indian Black
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner, must be notified at once	Fu	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	If Yes, specify Cuban, Mexican, Puert  1 Yes 2 No specify:		White, etc.  Specify: Whi	
ours af Iatural Xamin	d by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of during most of working life DO NOT use re	work done	16b. Kind of Business/Ir	
5-0036 led within 72 h Tygiene other than "n	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Homemaker	illed)	own home	2
21215-0036 Julid be filed within 7 Mental Hygiene marked other than c event, the Medica		17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma	,	
212' uld be Mental marke	To Be	Arley C. Carlson  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	Rural Route Numb		Zip Code)
MD d 2 sho lth and n 27 is numati		Thomas Long/ spouse	10741 Knife Box Road		n, Maryland	
e Hear I			Place of Disposition (Name of cemetery, crematory or other place) Censboro Cemetery Esapeake Cremation 05		20c. Location - City or Greensboro Ma	
Baltimor permit. Pages Department of Important: If		21. Signature of Funeral Service Licensee	22 Name and Address of Facility Fleegle and Helfen PO Box 160; Greens	bein Fun	eral ₃ Home,	PA
Physician		23a. Part In Enter the disease, or comprications that caused the death failure. List only one cause on each line	n. Do not enter the mode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a Narcotic (Morphine				Death
<b>6</b> - /		or condition resulting in death)  Due to (or as a consequence of Sequentially list conditions,	(10):			
	iner	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause	of):			
ecuted and transit	Examin	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of d.	of):			
760, cate be execut physician and he burial - tran	/Medical		-c,23a,27,28a-f,perME,g856,6,	/12/06 TT		
Box 68760, earth certificate be enthe attending physician of for use as the burial		IF FEMALE: 23b. Was decedent pregnant in the			23d. Date of delivery	
lox 687 leath certific e attending for use as t	ician	past 12 months?  4 Pregnant at time of de	2 Fetal death 3 Ectopic pregreath 5 Other (Specify)	ancy	Month Da	ay Year
Bo he deat the att	Physician	1 Yes 2 No 9 V Unknown 9 Unknown		Loo Billio		
, P.O.	Ď	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.		acco use contribute to the 2 V No 3 Proba	
of Vital Records, ng Physician: The law require After this certificate has been si nneral director, page 2 should b	Completed			24a. Was an		opsy findings available ompletion of cause of
Reco The law icate has	mo			perform 1 ✓ Yes 2	ned? death?	
tal Recian: The certificate ector, page	Be	25. Was case referred to medical examiner?	26.Place of Death (Check			
of Ving Physical After this funeral direction	٦.	1 V Yes 2 No Inspired 1 Inpatient 2 27. Manner of Death 28a. Date of Injury	ER/Outpatient 3 DOA Other Nursi  28b. Time of Injury 28c. Injury at Work?		esidence 6 🗸 Other:	Scene
ion c tending eath or: Af the fun	cation:	1 Natural 5 Pending Fnd 5//3/2006	Fnd 5:35 pm 1 Yes 2 No	unk		
Division Tal or Attendin Tal or Attendin Tal or Attendin Tal Director: Ted in by the fu	ifica	3 Suicide 6 X Could not be 28e. Place of Injury - At hi	ome, farm, street, factory, office building, etc.	28f. Location (Str	reet and Number or Rura	al Route Number, City
Div ospital or hours afte meral Div	Certific	4 Homicide determined (Specify) Fnd Resi		l Greensboro	o, Caroline Co	unty, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination a and praftice stated.				
	ž	29B. Signéture and title of certifler	29c. License number	1	29d Date signed (Moni	th, Day, Year)
	,	V KUTU VVI	O.C.M.E.		May 4, 2006	<u>.</u> .
		<ol> <li>Name and address of person who concleted cause of death (Item Susan Hogan MD. Assistant Medical Examiner</li> </ol>	· ·	1201		
Si Regis	tate trar	31. Date filed (Month, Day, Year) 2006 Registrar's Signatu	ure Jane			

			1- State Registrar C6	partment of Health and Mertificate of Death		piene 006 16404
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	Day Year
	/Medic	al	LUCILLE L. DUKES  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	MAY	02, 2006 8:05A M
	Examin	ier	HOLY CROSS HOSPITAL	SILVER SPRING		MONTGOMERY
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birthplace (State or Foreign
	Director		579 46 1775 1□ M XX F 98 Yrs.	Months Days Hours Min.	JAN . 24	, 1908 SOUTH CAROLINA
	and and		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or It	ocation		10d. Inside City Limits
	Maryl	tor	MARYLAND MONTGOMERY WHEATON			XXYes 2 □ No
	h the	Directo	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Country?
	death with the Maryland ms 23a or 28a-f show	ralD	11901 GEORGIA AVENUE	20902		UNITED STATES
	er de: Itams	Funeral	11. Marital Status	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
ر ا	urs aft al', or	by F	XX Widowed 4 Divorced Year or Dates:	1 ☐ Yes XX No Specify:		Specify: BLACK
2-003p	be filed within 72 hours after death with the Marylan Hygiene. At Hygiene. At other than "natural; or Itams 23a or 28a-1 show event, the Medical Examiner must be redified at	ompleted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation	20	16b. Kind of Business/Industry
	within ene. than "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of workii DO NOT use retired)	,9	
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	s 1 and 2 should be f Health and Mental itam 27 is marked o other traumatic ev		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ing Address (Street and Number or Rura		; City or Town, State, Zip Code)
2	os 1 and 2 of Health itam 27 i other tre		· · · · · · · · · · · · · · · · · · ·		-	TON, DC 20012
			M_ABurial 2   Cremation 3   Hemoval from State	ematory or other place)		20c. Location - City or Town, State
Бащтог	permit. Page Department of Important: If any injury or once.			AINS CEMETERY 05/12	PERSONAL PROPERTY AND ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NAMED IN COLUMN 2 ADDRESS OF THE PERSON NA	GAFFNEY, SC
מ	Depared Important any in			2. Name and Address of Facility MARSHALL'S FUNERAL 4308 SUITLAND ROAD	HOME OF SUITLA	MARYLAND, INC. ND, MD 20746
			23a. Part1 Enter the disease, or complications that caused the death. Do not en shock or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac o	r respiratory arre	est, Approximate Interval Between Onset and Death
-	Inysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. SMALL BOWEL OBST	RUCTION		Oliset and Death
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		Jer	Sequentially list conditions, if any, leading to immediate Cause Int Interpret Cause (Disease or injury)			
	acuted nd transit	Examine	that initiated events c.			
8/00,	cate be executed physician and the burial-transit	ai Ex	resulting in death) Last Due to (or as a consequence of):			
100	certificate Iding physi	edicai	d			
XOQ	leath certifica attending ph	M/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
	0 0 0	hysician/M	1 Yes XXNo 4 Pregnant at time of death 5	Other (specify)		Month Day Year
	res that the de signed by the a be detached f	۵.	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause awan in Part I	23a Did toh	pacco use contribute to the cause of death?
Ś	The law requires that the ate has been signed by the bage 2 should be detached.	d by	ATRIAL FIBRILLATION	and onlying cause given in trait.		es XXNo 3 Probably 4 Unknown
cords,	w requir s been si should	ete			24a. Was a	
ב	rsician: The faw s certificate has t lirector, page 2 s	Completed			autops perform 1 ☐ Yes X	y prior to completion of cause of death?
VII	Physician: The I this certificate ha ral director, page	Be C	25. Was case referred to medical examiner?	26. Place of Death		
> ·	hysic his ce il dire	To	1 ☐ Yes 2XXVIo Hospital: XXX Inpatient 2 ☐ ER/Outpatie		ne 5 🗆 Reside	nce 6 Other (Specify)
	or Attanding Physician: Ifter death. Diractor: After this certifica in by the funeral director.	ion:	27. Manner of Death  XX Natural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)  Injury	of 28c. Injury at 2 Work? M 1 Yes 2 No	8d. Describe ho	w injury occurred
2	I or Attandi after death. Diractor: A I in by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si		8f. Location (Str	reet and Number or Rural Route Number,
≥ .	al or A s after Il Dira	Certification;	4 ☐ Homicide determined building, etc. (Specify)	1001, 1001019, 01100	City or Town	
	To the Hospital or Attanding within 24 hours after death. To tha Funeral Diractor: After completely filled in by the funer	edical (	29a. Certifier  (Check only one)  XXCertifying Physician: To the best of my knowledge, dea  2 Medical Examiner: On the basis of examination and/or in  and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	nd due to the ca d at the time, da	tuse(s) and manner as stated. ate and place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Month, Day, Year)
			* XUKA	D58962		MAY 08, 2006
_(	3)		30. Name and address of person who completed cause of death (Item 23a) (Type SHASHANK RATEL, MD 2309	,	FATON	MD 20902
	Sta				LATUN,	20902
€.	Registr	ar	31. Date filed (Month, Day, Year)  MAY 1 1 2006  MAY 1 1 2006			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Amended items 10e&20b per fh Gertificate of Death wichd/09-1089006/dls 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 0008 YAN CES 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROGIONAL Medical PENINSULA CONTO SKISKI WICOMICO If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min. 1 □ M 2 🕱 F 90 Director 22 4023 EYMONT Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits rthen "natural", or items 23a or 28a-f ehov tre Mudical Examiner must be notified at WATTSVILLE 1 Yes 2 No A Director CCOMACK 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ONRO 33335 5. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: þ Whit 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12+1 Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill.
Department of Heelth and Mental Hy
Important: if item 27 is marked oth
eny injury or other traumatic event MAY Jorie M EDMONDS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FAVM RO (DAUGH) 33335 New Church Va 20c. Location - City or Town, State BONOWITZ PAT HANSON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State OAK HALL, UA 4 Donation 5 Other (Specify) OWNINGS 21. Signature of Funeral Service Licensee Funeral Home 22. Name and Address of Facility OK TensP. VA. Fut arnes 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examine physicien and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as been signed by the attending I should be deteched for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) P.O. 1 t ☐ Yes 2 ☐ No 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 5 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificete 1 ☐ Yes 2 ☐ No 21110 of Vital Attending Physician: ector. 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☑ No Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 □ DOA မှ this Director: After that in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) efter 4 | Homicide To the Hospital or within 24 hours eft To the Funerel Di completely filled in 1 Critifying Physicion: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number certifie H50497 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peninsuk Reginal Medical Center, Salebon, 4 D. J Jox 5

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 0 2006

**ORIGINAL** 

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** May 12, 2006 9:10 P M Mildred Murray Deuel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown ff Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🔀 F 028-10-5032 89 Director Jan 21, 1917 Massachusetts Usual Residence of Decedent within 72 hours after death with the Maryland 10d, fnside City Limits Pages 1 and 2 should be men memoriment of Health and Mental Hygiene.
tant: if Item 27 is marked other than "naturel", or Items 23s or 28s-f show itan; if Item 27 is marked other than "naturel", or item mat he notified at 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No St. Mary's Great Mills Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20634 USA 45961 Bates Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Efementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William S. Murray Everetta Penny 19a. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45961 Bates Road, Great Mills, MD 20634 Patricia Larnerd / Daughter 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Holy Name of Mary Casholic Cemetery permit. Page Department in Important: If eny injury or Montrose, PA 4 ☐ Donation 5 ☐ Other (Specify) May 19, 2006 21. Signat re f Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 270, Leonardtown, MD 20650 Approximate fnterval Between Onset and Death Immediate Cause (Final Physician cui ms disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Dement Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events physician and resulting in death) Last Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ğ Month Day Year 4☐ Pregnant at time of death 5 Other (specify) been signed by the a should be detached P.O. 9 Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No page 2 s 1 Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Tes 2 No after death. 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day; Year) 29b. Signature and tyle of certifier 0062213 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 22650 Cedar Lane Court, Leonardtown, MD 20650 Suresh H. Patel, M.D. Registrar's Signature 31. Date filed (MoMhANy, Year) 2006 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** ason 2006 suvenia Mai 30P /Medical Ac. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) hesapeake Dorchester Woods 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 218-20-4496 Usual Residence of Decedent 1 M 2 W F **Director** MarylaNo be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director Talbot 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30. -ateWai or items 23a 21 6 an 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: 3. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗖 No Baltimore, Maryland 21215-0036 Specify. 3 Widowed 4 □ Divorced Black 'natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) rivate Residence Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) is marked of tie Blackston ooper 10Ses Mat 2 Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print Department of Health a Important: if item 27 is any injury or other trauging. trappe, Md, 21673
20c. Location - City or Town, State 29099-Sanderstown Rd Brown -eola 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State Paradise Cemetery 5/16/06 Trappe, Maryland A □ Donation 5 □ Other (Specify) 22. Name and Address of acility at Hom Henry Funeral Hom 510 Washington St. 21. Signature of Funeral Service Licenses Home, Cambridge MD.21613 W 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Imbalance **Physician** electrolye Week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1101 allure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se a noneequence off Be Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transli pertens o Du (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 4 Pregnant at time of death signed by the e P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 No 3 Probably 4 Unknown dementi 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2 3-No 1 Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 ☐ LN6 2 ER/Outpatient 3 DOA his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certlfication: After 5 Pending investigation 1 Natural s effer de... ai Director: Atte 1 🗌 Yes 2 🗆 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after de le Funeral Directe letely filled in by to 4 Homicide 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number AL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bramble

State

Registrar

31. Date filed (Month, Day,

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2006

Year)

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32. Registrar's Signature

			1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment ertificate			and M		giene Reg. No.	2006	16408
	Physici	an	Decedent's Name (First, Middle, Last	)						2. Date of Dea	ath Day	Year	3. Time of Death
	/Medi		Herbert Wayne							May	15	2006	11:04 a ^M
	Examir	ner	4a. Facility Name (If not institution, give		-	4b. City, To				. 1.		ounty of Death	
			Calvert Memorial  5. Social Security Number 6. Se		a.L Age (In yrs. last birthday			Fred If Under				alvert	
	Funeral Director			M 2 F	70 Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Da 1-8-19)	y, Year)	Coun Kan	lace (State or Foreign ltry)
			Usual Residence of Decedent							1 0 1).	30	Kan	545
	rylan ihow	_	10a. State 10b. County		10c. City, Town or L	ocation						1	Od. Inside City Limits
	8e-f s	cto	Maryland St. Ma	ry's	Califor	nia							1 Tes 2 No
	with th	Dire	10e. Street and Number			10f. Zip C					•	n of What Coun	,
	s 236	eral	45277 Elmbrook Dr	1Ve 12. Was Decede		Wes Decide		0619	1-0 (0-	-76 - 36		ed Stat	
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. od other then "neturel", or Items 23e or 28e-f show event. I've Modical Exertings the profiled at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	es? □ No	If Yes, specify		Specify:		cify Yes or No- Rican, etc.)		. Race - Americ Black, White, opecify: Wh:	
Š	2 hou	Completed	15. Decedent's Edu		16a. Dece	edent's Usual	Occupa	tion			16b. Kind	of Business/Inc	
21	thin 7	npie	(Specify only highest grad Elementary/Secondary (0-12)	e completea) College (1-4	life	e kind of work DO NOT use	done d retired)	uring mosi	of workii	ng			
7	ed wi	Con	12			Navy		-				S. Navy	
pu	be fill tal H d off	Be	17. Father's Name (First, Middle, Last)							(First, Middle,		ımame)	
3	12 should be filled within h and Mental Hygiene. 7 Is marked other then "treumetic event, the Max	Ţ	Ernest Fisher	District.						e Turne		-	
Maryland	s 1 and 2 should f Health and Mer item 27 Is marke other treumetic		19a. Informant's Name/Relationship (T)									own, State, Zip	
d)	s 1 and 2 if Health item 27 I		Georgeanne Fisher/ 20a. Method of Disposition	Wite	20b. Place of Disp	osition (Name	of		ve.	Califor	nia, 20c. Loca	Marylai tion - City or To	nd 20619 wn. State
JO L	ages ant of st: If ii y or c		1 Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Removal from Sta	cometery, cre Evergree	-	•	· 1	10_	2006			, Maryland
Baltimore,	permit. Pages 1 Department of H Importent: If ite eny injury or ot		21. Signature of Funeral Service Licens	19/4	Since ?	2. Name and	Address	s ot Facilit	y Bri	nsfield	I Fune		ne, P.A.
			Kyle S. Simons  23a. Part1. Enter the disease, or compleshock, or heart failure. List only o		·							Jwii, IID	Approximate
	Pnysician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	. Cord	10 respira			コート					Interval Between Onset and Death
F	Examiner				as a consequence of):	O							
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	icate be executed physician and s the burial-transit	Examine	that initiated events	aw	te Righ	t 10	we	u e	DC+	neose	グハベ	20900	,
, 0,	e exe ian a urial-t		resulting in death) Last	• •	as a consequence /):	Cot	Prin	. /	a.	2001.0			
8760,	ate b	dical		d.	pheral	<u> </u>	- 1763			MEDI L	^		
9	ding p	0	IF FEMALE:	3c. If yes, outcome	me of prognancy								
). Box	e death certific he attending p led for use as	Physician/M	in the past 12 months?	1 Live birth	n 2 ☐ Fetal death 3[ t at time of death 5[	□Ectopic preg □ Other (spec	nancy ify)	12.			230	d. Date of deliver Month	Day Year
P.0	hat the de rd by the detached		9 Unknown  Part II. Other significant conditions con	atributing to deat	h but got reculting in the	andorheina anu	aa airra	n in Dort I		22a Did to	haaaa	anntributa to the	e cause of death?
ords,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	ted by			To but not resulting my tire t						es 2□N		ably 4 Dunknown
Vital Records,		Completed				<del></del>				24a. Was a autop: perfor	sy	prior to com death?	osy findings available apletion of cause of
Vita	icien: certific rector,	Be	25. Was case referred to medical examiner?	Jaanital:					of Death	(Check only or	10)		
of	Phys this al dii	J	1 Yes No	lospital:	The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon		Other	4 LI NUI				Other (Specify,	)
o	ing After uner	tion	Natural 5 Pending	28a. Date of J (Month,	Day Year) Injury	M 280	Work	at ? es 2.⊟N		8d. Describe h	ow injury o	ccurred	
Division	or Attending after death. Director: After d in by the funer	fica	3 Suicide 6 Could not be	28e. Place of	Injury - At home, farm, st			03 2 🗀 1	-	8f. Location (S.	treet and N	lumber or Rural	Route Number
Ο̈́		Certification:	4  Homicide	building,	etc. (Specify)					City or Tow			, , , , , , , , , , , , , , , , , , , ,
	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	ledical C	29a. Certifier (Check only one)	sician: To the be ner: On the basis and manner	est of my knowledge, dear s of examination and/or in stated.	h occurred at ovestigation, in	the time my opi	nion, deat	i place, a h occurre	nd due to the c	ause(s) and late and pla	d manner as sta ace, and due to	ated. the cause(s)
)	To the within 2. To the Complete	Me	29b. Signature and title of certifier  N. Herolo	70.	MD			number	38	HD 2		igned (Month, D	Day, Year)
			30. Name and address of person who co	mpleted cause o	of death (Item 23a) (Type, FRE DEX	Print) 10	0.	MI	920	17AL 2067	RO		#310.
	Sta Registr		31. Date tiled (Month, Day, Year) 7 2	006 ^{32. P(9)}	FRE DEX	ford							

Alical Plary Alice Fleming  4a. Facility Name (If not institution, give street and number)  Suburban Hospital  5. Social Security Number  6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Month, Day, Year)  1 M 285 F	sicia	an	Decedent's Name (First, Middle									2. Date of Month		Day	Year		e of Dea	ath
Substitute Hospital  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Control  South Security Work Cont	dic	al		/	and nu	mher)		4h Cih	v Town or	Location (	of Oeath	May	7,	Τ'			a	IVI
Security Number   0 Security   2 Age   10 Age   2 Age   10 Age   12 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age   10 Age	min	er			au io iiui	11001)			-	Location	or Death							
Table   10   10   10   10   10   10   10   1	al			6. Sex		7. Age (In yrs	s. last birthday,	If Unde	er 1 Year			8. Date o	f Birth		9. Birt	hplace (Sta	te or Fo	reigr
10	or			1 🗆 M	2 <b>⊠</b> F	88	Yrs.	MOTHERS	Days	nours	IVIII I.	_	- 1				a	
23a. Part I. Either the disease, or complications that caused tith death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between Death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cause (Final in each) Immediate Cau						10c. C	City, Town or L	ocation								10d. Insid	e City L	imits
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15. Decedents Education   15. Decedents State Occupation   15. Decedents State Occupation   15. Repetition of Programmer   15. Mother's Name (First, Middle, Last)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Sumane)   15. Mother's Name (First, Midlle, Marcan Sumane)   15. Mother's Name (First, Middle, Marcan Su		y Fi		lf.	Yes, Gr	ve		1 🗆 Yes	2 🔼 No	Specify:				Spec	cify:Whit	æ		
18. Mother's Name (Pists Middle, Last)   19. Mailing Address' Name (Pists Middle, Last)   19. Mailing Address' Name (Pists Middle, Last)   19. Mailing Address' (Street and Number or Rural Route Number, City or Town, State, Zip Code)   19. Mailing Address' (Street and Number or Rural Route Number, City or Town, State, Zip Code)   19. Mailing Address' (Street and Number or Rural Route Number, City or Town, State, Zip Code)   19. Mailing Address' (Street and Number or Rural Route Number, City or Town, State, Zip Code)   19. Mailing Address' (Street and Number or Rural Route Number, City or Town, State, Zip Code)   19. Mailing Address' (Street and Number or Rural Route Number, City or Town, State, Zip Code)   19. Mailing Address' (Street and Number or Rural Route, City or Town, State, Zip Code)   19. Mailing Address' (Street and Number or Rural Route, City or Town, State, Zip Code)   19. Mailing Address' (Street and Number or Rural Route, City or Town, State, Zip Code)   19. Mailing Address' (Street and Number or Rural Route, City or Town, State, Zip Code)   19. Mailing Address' (Street and Number or Rural Route, City or Town, State, Zip Code)   19. Mailing Address' (Street and Number or Rural Route, City or Town, State, Zip Code)   19. Mailing Address' (Street and Number or Rural Route, City or Town, State, Zip Code)   19. Mailing Address' (Street and Number or Rural Route, City or Town, State, Zip Code)   19. Mailing Address' (Street and Number or Rural Route, City or Town, State, Zip Code)   19. Mailing Address' (Street and Number or Rural Route, City or Town, State, Zip Code)   19. Mailing Address' (Street and Number or Rural Route, City or Town, State, Zip Code)   19. Mailing Address' (Street and Number or Rural Route, City or Town, State, Zip Code)   19. Mailing Address' (Street and Number or Rural Route, City or Town, State, Zip Code, Zip Code, Zip Code, Zip Code, Zip Code, Zip Code, Zip Code, Zip Code, Zip Code, Zip Code, Zip Code, Zip Code, Zip Code, Zip Code, Zip Code, Zip Code, Zip Code, Zip Code, Zip		ed					16a. Dece	edent's Us	uat Occup	ation			1	6b. Kind of	Business	Industry		
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19a Informant's Name/Relationship (Type, Pint)   19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cose)										18. Mothe					ame)			
Margaret Nicolson/ Niece   3909 Durmel Lane, Kensington, MD 2005   May Date   11,   2001   Location - City or Town, State   4 Denation   5 Other (Specify)   May Date   11,   2001   Location - City or Town, State   4 Denation   5 Other (Specify)   May Date   11,   2002   Location - City or Town, State   4 Denation   5 Other (Specify)   May Date   11,   2002   May Date   11,   2003   Location - City or Town, State   4 Denation   5 Other (Specify)   May Date   11,   2002   May Date   11,   2002   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date   11,   2003   May Date		0		.,			· · · · · · · · · · · · · · · · · · ·					<u>-</u>						**********
20a Method of Disposition (Name of Capacitics)   20b Place of Disposition (Name of Capacitics)   20c Location - City or Town, State   4   Donation 5   Other (Specify)   20c Location - City or Town, State   4   Donation 5   Other (Specify)   20c Location - City or Town, State   4   Donation 5   Other (Specify)   20c Location - City or Town, State   4   Donation 5   Other (Specify)   20c Location - City or Town, State   4   Donation 5   Other (Specify)   20c Location - City or Town, State   4   Donation 5   Other (Specify)   20c Location - City or Town, State   Holy Cross Cereterry   20c Location - City or Town, State   Holy Cross Cereterry   20c Location - City or Town, State   Holy Cross Cereterry   20c Location - City or Town, State   Holy Cross Cereterry   20c Location - City or Town, State   Holy Cross Cereterry   20c Location - City or Town, State   Holy Cross Cereterry   20c Location - City or Town, State   Holy Cross Cereterry   20c Location - City or Town, State   Holy Cross Cereterry   20c Location - City or Town, State   Holy Cross Cereterry   20c Location - City or Town, State   Holy Cross Cereterry   20c Location - City or Town, State   Holy Cross Cereterry   20c Location - City or Town, State   Holy Cross Cereterry   20c Location - City or Town, State   Holy Cross Cereterry   20c Location - City or Town, State   Holy Cross Cereterry   20c Location - City or Town, State   Location - City or Town, State   Location - City or Town, State   Location - City or Town, State   Location - City or Town, State   Location - City or Town, State   Location - City or Town, State   Location - City or Town, State   Location - City or Town, State   Location - City or Town, State   Location - City or Town, State   Location - City or Town, State   Location - City or Town, State   Location - City or Town, State   Location - City or Town, State   Location - City or Town, State   Location - City or Town, State   Location - City or Town, State   Location - City or Town, State   Location - City or Town, State   Location -					rint)										vn, State. 2	Zip Code)		
## Bursal 2   Cremation 3   Removal from State   Holy Cross Cemetery   2006   Finocugh of Darby, Pennsylval   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   22   Name and Address of Facility   23   Name and Address of Facility   23   Name and Address of Facility   23   Name and Address of Facility   23   Name and Address of Facility   23   Name and Address of Facility   23   Name and Address of Facility   23   Name and Address of Facility   23   Name and Address of Facility   23   Name and Address of Facility   23   Name and Address of Facility   23   Name and Address of Facility   23   Name and Address of Fac	l			Niece		20b.	Place of Disp	osition (N.	ame of			3010			n - City or	Town, State	9	
21. Signature of Funeral Service Licensee  Parancial J. Collains Runeral Home Inc.  Sou University Bivd, W, Silver Spring, MD 20901  23a. Part. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate mediate Cause, Final female and the conditions, causes final death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate mediate Cause, Final female and Death Immediate Cause, Final female and Death Immediate Cause, Final female and Death Immediate Cause, Final female and Death Immediate Cause, Final female and Death Immediate Cause, Final female and Death Immediate Cause, Final female and Death Immediate Cause, Final female and Death Immediate Cause, Final female and Death Immediate Cause, Final female and Death Immediate Cause, Final female and Death Immediate Cause, Final female and Death Immediate Cause, Final female and Death Immediate Cause, Final female and Death Immediate Cause, Final female and Death Immediate Cause, Final female and Death Immediate Cause, Final female and Death Immediate Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final female Cause, Final femal			1 🛣 Burial 2 ☐ Cremation		val from		-	-		(e)			4.57					
23a. Part in disease, or combinations that caused timideath. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate Interval Between Onset and Death   Due to (or as a consequence of);						110				ss of Facilit					or bar	.by, rei	шзут	.va
Approximate interest the disease, or complications that caused this death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset and Death Interest Between Conset Interest Between Conset Interest Between Conset Interest Between Conset Interest Between Conset Interest Between Conset Interest Interest Between Conset Interest Interest Between Conset Interest Interest Between Conset Interest Interest Between Conset Interest Interest Between Conset Interest Interest Between Conset Interest Interest Between Conset Interest Interest Between Conset Interest Interest Between Conset Interest Interest Interest Between Conset Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest In		П	10000	4	)	Qen .									0.2090	1		
FFEMALE:   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year   1   Yes   2   Zo   Zo   Month   Day   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year			disease or condition resulting in death)  Sequentially list conditions,	a. Pi	ilmon Due to ip-Re	ary Embo (or as a conse placemen	olus equence of): at Surger		ode of dyin	g, such as	cardiac	or respirato	ory arre	st,		Interval	Betwee	
1   Yes   2   No   3   Probably   4   Mas an autopsy performed?   1   Yes   2   No   24a. Was an autopsy performed?   1   Yes   2   No   No   1   Yes   2   No   No   No   No   No   No   No		Examln	disease or condition resulting in death)  Sequentially list conditions, if any, leading to inmiddlate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Pr	lmona Due to ip-Rep	ary Embo (or as a conse placemen	olus equence of): at Surger equence of):		ode of dyin	g, such as	cardiac	or respirato	ory arre	st,		Interval	Betwee	
25. Was case referred to medical examiner?  15C Yes 2 No  26. Place of Death   Check only one    27. Manner of Death   15C Natural   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1 Yes 2 No  28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1 Yes 2 No  28b. Place of Death   Check only one    28c. Place of Death   Check only one    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier   1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)  29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)		ical Examin	disease or condition resulting in death)  Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No	a. Pi b. — c. Qi d. —	Due to Due to Due to Due to	ary Finds (or as a conse	plus squence of): at Surger squence of): squence of): squence of):	y □Ectopic	pregnancy		cardiac	or respirato	ory arre	23d. I		Interval Onset a	Betweend Dea	th .
25. Was case referred to medical examiner?  15 Yes 2 No  27. Manner of Death  15 Natural 28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Descr		by Physician/Medical Examin	disease or condition resulting in death)  Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	a. Pi b. — c. Ot d. — 23c. If	Due to Due to Due to O	ary Finds (or as a consecution of pregoint)    Comparison of pregoint   2   Fe nant at time of own	plus squence of):  It Surger squence of):  poquence of):  nancy tal death 3   death 5	Sy □Ectopic □ Other (a	pregnancy			23e.1	Did toba	23d. I	Month ontribute to	Initerval Onset a	Year	r h?
27. Manner of Death 11 Natural 2   Accident 3   Suicide 4   Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M 1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Desc		ompleted by Physician/Medical Examin	disease or condition resulting in death)  Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	a. Pi b. — c. Ot d. — 23c. If	Due to Due to Due to O	ary Finds (or as a consecution of pregoint)    Comparison of pregoint   2   Fe nant at time of own	plus squence of):  It Surger squence of):  poquence of):  nancy tal death 3   death 5	Sy □Ectopic □ Other (a	pregnancy			23e.	Did tob.	23d. I	ontribute to 3 Pr	ivery Day  the cause obably 4 sutopsy finding completion	Year  of death	r h? nown
29a. Certiflier  (Check only one)  29b. Signature and title of certiflier  29c. Certiflier  (Check only one)  29b. Signature and title of certiflier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)		Be Completed by Physician/Medical Examin	disease or condition resulting in death)  Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown  Part II. Other significant conditions.	a. Pi b. — c. Of d. — 23c. If 1 4 9 ons contribu	Due to the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pre	ary Finds (or as a consecution of pregoint)    Comparison of pregoint   2   Fe nant at time of own	plus squence of):  It Surger squence of):  poquence of):  nancy tal death 3   death 5	Sy □Ectopic □ Other (a	pregnancy specify) g cause give	en in Part! 26. Place		23e. l	Did tob:	23d. I 1 1 acco use co s 2 □ No 24l (ed? \$\forall \text{1} \text{No}	ontribute to 3 Pr	ivery Day  the cause obably 4 sutopsy finding completion	Year  of death	r h?
29a. Certifier  (Check only one)  29b. Signature and title of certifier  29c. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)		To Be Completed by Physician/Medical Examin	disease or condition resulting in death)  Sequentially tist conditions, if any, leading to inmiddate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Prob. H. b. H. c. Qr. d. 23c. 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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🕦 🕦 💍 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Matthew J. Fenton 05 2006 May /Medical 334 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Naval Medical Center

ocial Security Number 6. Sex 7. Age (In yrs. last birthday) Bethesda, MD Montgomery County If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JAN. 17, 1982 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days 1**∑**M 2□ F Director NEW JERSEY 150-82-9143 24 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any joury or other traumatic event, the Mexical Exactly activated by notified at once. 10d. Inside City Limits Director Y☐Yes 2☐No LITTLE FERRY N.J. BERGEN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 125 MAIN ST. #1 07643 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married TYPES 2 No 2000-If Yes, Give 2000-Year or Dates: 2006 Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 ▼ No Specify: ģ 3 Widowed 4 Divorced 2006 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. MARINE DEFENSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN Τ. FENTON DIANE VAGTS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 MAIN ST. #1, LITTLE FERRY, N.J. 07643 FENTON/MOTHER DIANE 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CEDAR LAWN CREMATORY 5-13-2006 PATERSON, N.J. 21. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Penetrating Ballistic Wound to the Head **Physician** 10 Days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1X Yes 2□ No 1X Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 XInpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 XYes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 | Natural 5 Pendina April 25 2006 UNK. 1 Nes 2 No 2 Accident Improvised Explosive Device 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 XHomicide Iraq within 24 hours a To the Funeral C Iraq 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 X Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD - 13283 HI May 06, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARMED FORCES INSTITUTE OF PATHOLOGY Philip 1413 Research BLVD Berran Rockville, MD 20850 31. Date filed (Month, Day, Year)

MAY 1 0 2006 32 Registrar's Signature Registrar

Day

2. Date of Death

3. Time of Death

8:27 AM

	/Medic		JOSEPH	I MARCE	L ROLAND	GAG	NON							MAY	9	2	006	8
	Examin		4a. Facility Name (	If not institutio	n, give street and no	ımbər)			4	b. City,	Town, or	Location	of Death		4	c. Coun	ty of Deat	th
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	Funeral		5. Social Security N	Number	6. Sex			last birthda		If Under	1 Year Days	If Unde	r 24 Hrs. Min.	8. Date of Bir (Month, Da	th Yes	r)	9. Birt	thplace (S
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ary	shot and A ama uma		19a. Informant's N	lame/Relation:	ship (Type, Print)			19b. Ma	iling	Address	(Street a	and Numb	er or Ru	ral Route Numb	er, City	or Town	, State, Z	Zip Code)
Ž	nd 2		MARION	GAGNON	/WIFE			216	42	JAC	KSON	POI	NT,	TILGHMAI	, l	<b>1</b> D 2	1671	
Baltimore,	Pages 1 a lent of Hes nt: If Item ry or otha		20a. Method of Dis 1 Burial 2 4 Donation	Cremation	3 □Removal from	State	0	Place of Discemetery, c	remai	tory or o	ther plac			Date 5/16/200			- City or '	
Balti	permit. Departm Imports any inju		21. Signature of Fu	moral Service	Licensee	1	. 0	7	22. N	LOW	d Addres	s of Faci	ity NBEII	N & NEWI	IAM	FUN	ERAL	

1. Decedent's Name (First, Middle, Las-

TALBOT 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign OCT 28 MICHIGAN 10d. Inside City Limits 1 XYes 2 □ No 10g. Citizen of What Country? USA dent of Hispanic Origin? (Specify Yes or No cify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. WHITE Specify: 16b. Kind of Business/Industry SELF EMPLOYED BUILDER 18. Mother's Name (First, Middle, Maiden Sumame) GERTRUDE BERARD

> Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

06

Year

4 Unknown

Physician

JOSEPH M. GAGNON

physician and the burial-transit requires that the death certificate be executad as nse s ed by the a s been signed b page 2 certificate or Attending Physician: this funeral After within 24 hours after death.

To the Funeral Diractor: A
completely filled in by the fu filled in by To the

/Medical Examiner Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical ģ Completed Be Certification: Medical

4 | Homicide

(Check only

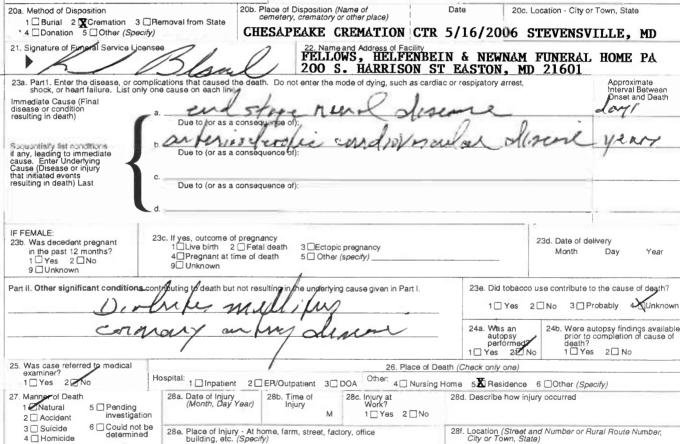
29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 1 2006

29a. Certifie



State

Registrar

ROBERT B. SANCHEZ, M.D. 508 IDLEWILD AVE., EASTON, MD 21601

Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1125750

			1 - For State Registrar	State of Maryla			of Health a		Reg	g. No.	06	6	+12
	Physici		1. Decedent's Name (First, Middle, Last)	Sherry Lee	Gass				2. Date of Death Month May 16	Day	Year	3. Time o 5:19	
	/Medio		4a. Facility Name (If not institution, give			4b. City, 7	Town, or Location of	of Death		4c. County	of Death		
			41730 Eldon Court				nardtown			Sain	t Mar	ry's_	
*	Funeral Director		0/9-00-000/	7. Age (In y.	37 Yrs.	If Under Months	1 Year If Under Days Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 1 May 15,	1969	9. Birthi Cou New	place (State ntry) York	or Foreign
	/and		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation						10d. Inside C	City Limits
	Ba-f sh	Funeral Director	Maryland Saint Mar	ry's	Leonard								2 X No
	with the	Dire	10e. Street and Number			10f. Zip			10	g. Citizen of 1		ntry?	
	eath me 23	era	41730 Eldon Court	12. Was Decedent Ever in	IIS 13	_	20650	igin? (Spe	city Yes or No-	US.		can Indian,	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatib and Mental Hygiene. Department of Heatib and Mental Hygiene.  Brootent: If Item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other treumatic event, Ite Medical Erabil er must be notified at angle.	by Fun	1 ☐ Never Married 2 █ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 X Yes 2 □ No If Yes, Give Year or Dates:		If Yes, speci 1 ☐ Yes 2	ent of Hispanic Original of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of th		Rican, etc.)	Blad	ok, White, Whit	etc.	
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Ē	Page:		1XXBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	iemovai irom State	harles Me	_	_	May 19	, 2006 Le	eonardto	wn, Ma	aryland	
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V . A.,	Physician		23a. Parti. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final	cations that caused the de ne cause on each line.		ter the mode		cardiac o	. •			Approxima Interval Be Onset and	tween
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a cons	sequence of):								
	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):								
8/00,	rate be executed hysicien and the burial-transit		that initiated events resulting in death) Last	Due to (or as a cons	equence of):								
200	ificate g phys as the	edic		J									
F.O. DOX	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	3c. If yes, outcome of preduction 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3[	⊒Ectopic pre ⊒ Other (spe					te of deliventh	•	Year
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DIVISION OF VITAL RECORDS,	fhe law rec le has beel age 2 shou	Completed							24a. Was an autopsy perform	ed?	Were auto prior to co death? I  Yes	opsy findings ompletion of c	available cause of
<u> </u>	ian: rtifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place	of Death	(Check only one	A		20110	
N 01 V	Tokhe Hospital or Attending Physician: The within 24 bours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	မ	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	ER/Outpatie		A Other: 4 Nu Bc. Injury at Work?	ursing Hon	ne 5 Residen 28d. Describe how			fy)	
<u>0</u>	tendii Jeath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	GO. Blood deliver A		М	1 Yes 2		106 Lanation (Ct			-10	
2	ital or Al rs after o al Direc	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)				28f. Location (Stre City or Town,	State)			noer,
t_	Othe Hospital ithin 24 hours o the Funeral ompletely filled	edicai	29a. Certifier 1 Certifying Phy: (Check only 2 Medical Exami	sician: To the best of my l ner: On the basis of exam and manner stated.	knowledge, deal ination and/or in	th occurred a extraction,	at the time, date an in my opinion, dea	nd place, a oth occurre	and due to the cau ed at the time, dat	ise(s) and ma e and place,	anner as s and due to	stated. o the cause(s	s)
()	Toth within To th compl	Me	29b. Signature and title of certifier	21 01		29c.	License number	- / /		d. Date signe		_	
•			1	shan			D 47	060	0	5-1	6 .0	8	
			30. Name and address of person who co					3.5	4				
100	Sta	ate	A.D. Shah, M.D. St.  31. Date filed (Month, Day, Year)	Mary's Medical  32 Registrar's Signature  32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 32 Registrar's Signature 33 Registrar's Signature 34 Registrar's Signature 34 Registrar's Signature 35 Registrar's Signature 36 Registrar's Signature 36 Registrar's Signature 37 Registrar's Signature 37 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 Registrar's Signature 38 R		•	Leonardtow	n, Mar	yland 2065	X)(X)			
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			For State of N	•	artment of Health and <b>I</b> rtificate of Death	Mental Hygien	2000 10413				
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Dorothy Este	lle	Gerardi	2. Date of Death Month 17	3. Time of Death 10:10 Рм				
	Examin		4a. Facility Name (II not institution, give street and number 1213 Jefferson Blvd		4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington				
85%	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 反 F 7. A  Usual Residence of Decedent	Age (In yrs. last birthday, 73  Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea July 26,	9. Birthplace (State or Foreign Country) 1932 Pennsylvania				
	aryland show		10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits 1 X Yes 2 □ No				
	the Mg	ecto	MD Washington  10e. Street and Number	Hagerst	OWN 10f. Zip Code	100.0	Citizen of What Country?				
	3a or	ם ב	1213 Jefferson Blvd.		21742		U.S.A.				
36	s after deat or Items?	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Yes, Give	s? ŢNo	Was Decedent of Hispanic Origin? (S. If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White				
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28s-f show say injury or other traumatic event, the Medical Exactinar must be notified at ance.	Completed b	3 ¼ Widowed 4 □ Divorced Year or Dates  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12) College (1-4o	16a. Dece (Give	ndent's Usual Occupation to kind of work done during most of wor DO NOT use retired)	tking 16b.	Kind of Business/Industry				
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ary	should nd Me mark umati	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street and Number or Ru		or Town, State, Zip Code)				
	and 2 saith a n 27 le		Barbara A. Gerardi/Daughte		Jefferson Blvd.,						
lore	ges 1 it of He if iter or oth		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State	(8)	matory or other place)		Location - City or Town, State				
Baltimore,	permit. Pa Departmer Important eny injury		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	2		st Haven F	gerstown, MD uneral Chapel cstown, MD 21742				
8760, ~	Physician but and physician and physician and physician and physician and state is the purial-transit	dical Examiner	23a. Part 1. Enter the disease, or compiled ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one eause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
O. Box 6	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	by Physician/Med		2 Fetal death 31 at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year				
rds, P.	w requires that been signed t should be deta		Part II. Other significant conditions contributing to death		bacco use contribute to the cause of death? es 2000 3 Probably 4 Unknown						
Vital Record	The law requisate has been page 2 should	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No				
Vita	Physician: this certificand director.	Be	25. Was case referred to medical examiner? Hospital:	0.000	Other	th (Check only one)					
Division of	ding P. After fune	atlon: To	27. Manger of Death 28a. Date of Ir		nt 3 DOA 4 Nursing H	ome 5X Residence 28d. Describe how in					
Divis	Hospital or Attendi     Hours after death.     Funeral Director: A     etely filled in by the fi	Certification:		Injury - At home, farm, st etc. (Specify)	reet, factory, office						
	To the Hospital or Attenwithin 24 hours after deat to the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)  Certifying Physician: To the best and manner	of examination and/or in	nvestigation, in my opinion, death occu	rred at the time, date a	nd place, and due to the cause(s)				
)	To the within 2 To the complet	Σ	29b. Signature and title of sertifier	1 John	MD 29c. License number	73 /	Pay 18, 2006				
	6		30. Name and address of person who completed cause o	f death (Item 23a) (Type  MD 1 13  strar's Signature	O OPAL C	T. Hag	erstown, mis				
	Sta Registi		MAY 2 4 2006	, It Apa	W						

06-03285

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene David T. Hill 2006 16414 1. For State Amend #11 Per INF G860Caloridate06 Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Time of Death Physician/ Month Day May 16, 2006 0700 hrs **Medical Examiner** Thomas Hill David 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 3915 Oliver Street Hyattsville Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** oreigWash.D.C. Hours Director 1x M 2 F 214-94-1676 41 Yrs Dec. 27, 1964 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 No Prince George's Hyattsville Md. hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3915 Oliver St. 20782 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, 8lack, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 2 X No Yes Yes 2XX No specify: Specify: White 3 Widowed If Yes, Give Year ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be men venue.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "
Important: If item 27 is marked other than " Baltimore, MD 21215-0036 12 Musician Music 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ear1 Thomas Hill Dorothy Lee Hash 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2272 Calle Pulido Santa Fe, New Mexico 87505 Dorothy L. Hill (Mother) 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Chambers Crematory May 23,06 Riverdale, Md. Donation 5 Other Specify Chambers funeral Home & Crematorium, P.A. Riverdale, Md. 20737 21. Signature of Funeral Service Licenses ams romas 5801 Cleveland Ave. Riverdale, Md. 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Retween Onset and /Medical Death Mixed drug intoxication (Methadone and Cocaine) Immediate Cause (Final disease Examiner Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and ed for use as the burial - transit Physician/Medical X UNPENDED AMENDED item#23a,27,28a-f,perME,g858,8/25/06 TT Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 V No 3 Probably 4 Completed 24a Was an 24b. Were autopsy findings available After this certificate has been prior to completion of cause of autopsy performed? death? ✓ Yes 2 ✓ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 Other: A Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 1 Yes 2 No Pending Fnd 5/16/2006 Fnd 6:45 am unk Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide or Town, State) 3915 Oliver Street determined (Specify) Found: at home Hya<u>tts</u>ville. Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 17, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 1/2001 OCMF 2006

State

Registrar

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 6 1- State Amended 20b, 20c, 5/15/06, LDB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 2:00PM HILBURN 06 Mai 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Elliott aston Road Talbot If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Min 100 M 2□F Months Days Hours 219-42-7923 Yrs. Director Maryland JUNE 14 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show items 23a or 28a-f show ther must be notified at 1 Ves 2 □ No Completed by Funeral Director a 60 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2160 n 12. Was Decedent Ever in U.S. Armed Forces? 96.4 1 Dres 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status event, the Medical Examiner 72 hours after 1 Never Married 2 Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 Z No Specify: If Yes, Give Year or Dates: 1967 Black 3 Widowed 4 Divorced 'neturel' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Project Manager State marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be to and Mental F Aisley Hilburn Hexander Ida 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) , 1 and 2 s of Health a MD. 21601 HOPKINS Place Easton arolyn other Baltimore, 20c. L cation - City or Town, State Hurlock, MD 20b. Place of Disposition (Name of cemetery, crematory or other to Veter ans Cemet 20a. Method of Disposition Cemetar ö 1 Burial 2 Cremation 3 Removal from State ō `4 ☐ Donation 5 ☐ Other (Specify) Cambri 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P. A. HENRY Funeral Home, 23a. Party Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such a cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arrest, smoother than the cardiac or respiratory arr Cambridge, MD. 2161 Approximate Interval Between Onset and Death Immediate Cause (Final Arrythmia Cordiac **Physician** Leens disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit death certificate be executed Due to (or as a consequence of): physician Physician/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Ď Dav 4 Pregnant at time of death 5 Other (specify) P.O. the a 9☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, by Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page certificate 2 X No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Othe 8223 Elliott Rd Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 🗌 Yes 2 this 28d. Describe how injury occurred Parking lot the funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: After Hospitel or Attending 1 X Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 24 hours after death e Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the

State 'Registrar

31. Date filed (Month, Day, Year) 1 0 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



within ;

29c. License number

20051067

29d. Date signed (Month, Day, Year)

05/09/06

DHMH 17 Rev 1/2001

State Registrar

MAY 1 0 2006

32. Registrar's Sign

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	,	Certific	cate of	Death		R	eg. No.	10 1041
Physici	an/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month Day Year								3. Time of Death
edical Exami	ner	Christopher Leon Hardy May 7, 2006  4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death								2340 hrs
		5018 57th Avenue				Bladensbur	g		Prince Georg	e's
Funeral Director		5. Social Security Number 315-94-9209		(In yrs. last b	irthday) Yrs.	If Under 1 Year Months Day			rth(MM/DD/YYYY) 9 Bi 16, 1977 Forei	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Memial Hygiene Important: If item 27 is marked ofter than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a State 10b. County  Maryland Prin  10e. Street and Number  2202 Matthew  11. Marital Status  1 X Never Married 2 M	Henson Avenue  12. Was Decedent E Armed Forces? 1	Hyat  Hyat  Ever in U.S.  No  Deleted) 16a  +) 1  Cher 2  20b. Place te cremited in the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of	13. Was If Ye  1 Decedent during mo  Fact  9b. Mailing 181 E of Dispositatory or other  ony Me	Don  1e  10f. Zip Code 207  Decedent of Hiss, specify Cubar  Yes 2 No s Usual Occupa st of working life  Ory Wor  Address (Street  verette lion (Name of ceer place)	85 spanic Origin, Mexican, specify: stion (Give kender) 18.Mother: set and Num Ct; metery, Park	in? (Specify Yes or Not Puerto Rican, etc.)  kind of work done use retired)  s Name (First, Middle, Delores Loter or Rural Route Nur Waldorf, May 13,2006	Og. Citizen of What Cou United  14. Race - Amer White, etc.  Specify: B1:  16b. Kind of Business.  Pr  Maiden Surname)  ndon  mber, City or Town, State	10d. Inside City Limits 1 X Yes 2 No untry? States rican Indian, Black, ack /Industry ivate e, Zip Code)
Physician /Medical Examiner	Examiner	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	complications that caused to on each line.  a. Gunshot Wound  Due to (or as a conserve)  Due to (or as a conserve)	to the Hea	Pop	e Funer	al Ho	mes; 5538 1		ke; MD 20747 Approximate Interval Between Onset and Death
', P.O. Box 68760, tres that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit	by Physician/Medical	events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in treat 12 months?  1 Yes 2 No 9 Un  Part II. Other significant conditions and the significant conditions are significant conditions.	d.  AMENDED  23c. If yes, outcom 1 Live birth 4 Pregnant at t	e of pregnanc	2 Feta 5 Oth	al death 3 er (Specify) inderlying cause		rt I. 23e Did t	23d. Date of deliver Month  bbacco use contribute to  2 No 3 Pro	Day Year the cause of death?
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical Certification: To Be Completed	2 Accident Inve 3 Suicide 6 Cou 4 Memicide 29a Certifier (Check only one) 2 Medical Exa 29b. Signature and title of certifier one) 30 Name and address of purson	Hospital: 1 Inpatier  28a. Date of Injur FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. Ye FOWNIT: 0ay. 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			State of Maryland / Dep 1- State Registrar Amend Item #5 Per FH G855 5/26		/giene 006 164 18
}	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last)  Robert Hawkins  4a. Facility Name (If not institution, give street and number)	2. Date of D Month 4b. City, Town, or Location of Death	eath Day 2006  4c. County of Death  4c. County of Death
F.	Funeral Director		Doctors Community Hospital  5578 □ 578 □ 578 □ 6. Sex	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Days 1/10/	Prince George's  9. Birthplace (State or Foreign Country)  13 Orangeburg, S.C.
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Maryland 21215-0036	d othe	To Be Co	17. Father's Name (First, Middle, Last)  Cornelius Hawkins	18. Mother's Name (First, Middle Viracious Sal	e, Maiden Surname)
	t d		Mattie R. Nichols/Friend 4439	iling Address (Street and Number or Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Ro	
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Balti	Department of Important: If it any injury or one			22. Name and Address of Facility H.S. Washington & Sons Co 4925 Burroughs Ave., N.E.,	, Inc.
443	hysician /Medical xaminer	cal Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		Approximate Interval Between Onset and Death  MM (C Mown)
The law requires that the death certificat		Physician/Medl		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
OS, T	signed b	Ď	Part II. Other significant conditions contributing to death but not resulting in the		tobacco use contribute to the cause of death?  Yes 2 \( \subsection \) No 3 \( \subsection \) Probably 4 \( \subsection \) Unknown
al Kecol		Completed	Uring tract infection.  postate canun	24a. Wa auc per 1 🗆 Yes	prsy prior to completion of cause of death?
DIVISION OF VITAL RECORDS,	uth. r: After this certif e funeral directo	ertification: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  1  Anner of Death 1  No Natural 5  Pending 2  Accident investigation  28a. Date of Injury (Month, Day Year)  (Month, Day Year)	of 28c. Injury at 28d. Describe	
DIVIS	within 24 hours effer death.  To the Funeral Director: After th completely filled in by the funeral	(Street and Number or Rural Route Number, wn, State)			
T of	n 24 hou he Funei pletely fil	edical	29a. Certifier  (Check only one)  1 ☑ Certifying Physician: To the best of my knowledge, dea  (Check only one)  1 ☑ Certifying Physician: To the best of my knowledge, dea  (Check only one)	ath occurred at the time, date and place, and due to the investigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
ן בֿ	Tot	W	29b Signature and title of certifier  Ratur Fallon M. 0	29c. License number D 4 3 4 4 6	29d. Date signed (Month, Day, Year)  5. 8. 06
2	Va		30. Name and address of person who completed cause of death (Item 23a) (Type ROINTAN FARAH FAR 980 i	Georgia Au Suit 3-41 S.	
	Sta Regist		31. Date filed (Month, Day, Year)  MAY 1 0 2006	Se la la la la la la la la la la la la la	

State of Maryland / Department of Health and Mental Hygiene ) Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month May **Physician** 2006 12:50 A.M Charles Theodore Hopkins, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9118 Fox Park Road Prince George's Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5/27/11 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) Months Hours 15 M 2□F 94 Yrs. 214-28-4250 Director Wash.,D.C. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or then "natural", or iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director Md. P.G. Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9118 Fox Park Road 20735 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. African-Specify: American 1 Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education a. Decement's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Commercial/Residential
Leal Estate Owner (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Small Business 2 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be it. Pages 1 and 2 should be riment of Health and Mental reart: If tem 27 is marked o William Hopkins Addie Hill ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara C. Hopkins/Wife 9118 Fox Park Rd., Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 6 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/12/06 Lincoln Mem. Cem. Suitland, Maryland Injury 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Sons Co. Inc. 4925 Washington & Sons Co. Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee Snow Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Parkinson's Disease **Physician** /Medical Due to (or as a consequence of) Examiner Alzheimer's Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physicien and for use as the burial-transit Decubitus Ulcer Due to (or as a consequence of) Box 68760 ician/Medicai as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the e Physi 9□ Unknown 9 Unknown cete has been signed page 2 should be det Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete has autopsy 2 No 1 ☐ Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; or Attending Injury 5 Pending investigation 1 Natural after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058686 May 9,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thu Nguyen, M.D. 6104 Old Branch Ave., Temple Hills, Md. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 1 0 2006

			For State Registrar	State	of Maryl		artment of H			Re	g. No. ZU	06	16420	
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	ems ?	Funerai	11. Marital Status	12. Was De Armed F	cedent Ever	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origir n, Mexican, I	n? (Specify Y Puerto Rican	es or No- , etc.)		e - Americ k, White,	ean Indian, etc.	
36	s after , or it		1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes C	2X No		1 ☐ Yes 2 No	Specify:			Specify	BLA	CK	
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Maryland 21215-0036	uld be file Aenta! Hy rked oth	To Be (	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  TTMMTE SHI						t, Middle, A HEPAR					
Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Hygiene Standard of Hygiene.  Department of Hygiene.  Department of Hygiene.		19a. Informant's Name/Relations SABRINA HALL/I				FOREST TI						0 Code) 0785	
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Baltimore,	permit. Depart Import eny in		21. Signature of uneral Service	Licensee			22. Name and Addres 7474 LANDO				INS FUN R, MARY			
1			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause or	caused the	death. Do not	iter the mode of dyin	g, such as ca	ardiac or resp	oratory arre	est,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a/	154	Thol	2						On Social Country	
	/Medical Examiner		resulting in death)	Duet	o (or as a co	sequence of):	· ·							
	of or on	er	Sequentially list conditions,	b. Due t	o (or as a cor	ns_quence of):								
	be executed sicien and burial-transit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events  c											
ó	be executed icien and burial-transit	Еха	resulting in death) Last	Due t	o (or as a co	nsequence of):								
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x 68	The law requires that the death certificat. Ite has been signed by the attending phy page 2 should be detached for use as th	/Med	IF FEMALE:	23c If yes o	utcome of pr	egnancy					334 Day	te of delive	90/	
Box	atten for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 🗆 gnant at time	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)				Moi		Day Year	
0	t the de by the a tached	hysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□Unl										
D,	es that igned t	by P	Part II. Other significant conditi	ons contributing to	death but no	t resulting in the	underlying cause give	en in Part I.	2				he cause of death?	
ord	w require been sig should b		Myere	yron.	7) 1	2				1 □ Y€	es 2□No	3 Prob	oabły 4∑∏Unknown	
ec	e law r has be je 2 sh	Completed	Time +	+ Dig	Kel	y			2	4a. Was a autops	SV E	prior to co	psy findings available impletion of cause of	
<u>~</u>		Con	01						1	perform		death?	212 No	
Vital Records,	Physician: T this certificat rat director, p	Be	25. Was case referred to medical examiner?	Hospital:		4-2	ont 30 DOA Oth	00	of Death (Che		*			
of		. To	1 Yes 2 No 27. Manner of De th	28a. Dai	Inpatient e of Injury	2 FR/Outpati	BIII 3E DOV	4 🗀 14013			ow injury occurr		ý)	
on	Attending I r death. ector: After by the funer	ation	1 Natural 5 Pendii 2 Accident investi	19	onth, Day Ye	ar) Injury		k? Yes 2∐N∈	lo					
Division	I or Attendi after death. Olrector: A I in by the fu	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							ocation (St City or Town		er or Rura	al Route Number,	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edicai C		Examiner: On the			ath senumed at the tin investigation, in my o							
	To the within 2 To the complet	Med	29b. Signature and title of certifie		-/ /	11/	29c. Licens	e number		2	9d. Date signer	d (Month,	Day, Year)	
	2		Figuron	HRIANDA	12/	JUA-	(1) N2	D989			5/9	106		
	Coci		30. Name and address of person	who completed ca	us of death	23a) (Tyr	rint)	20	acis		4	-		
	29		6005 LAND	OVER P	D) (	HEVER	cy, dud.	20	785					
	Sta Regist		MAY 1 0 2006	Kenne	Registrar's	diam's	r							

06-03052 Calvin Harris

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 2006 161.21

		l- For State Registrar	Certificate	e of Death		g. No.	10 1042		
Physicia Iedical Examir	n/	1. Decedent's Name (First, Middle,Last) Calvin Lewis	Harris		2. Date of Death Month May 5, 200	Day Year )6	3. Time of Death 2011 hrs		
		4a. Facility Name (if not institution, give street and number) 4875 St. Leonard's Road		4b. City, Town, or Location of St. Leonard's	of Death	4c. County of Deat Calvert	h		
Funeral Director		5. Social Security Number 6. Sex 7. Age 214-72-3699 1 X M 2 F	(In yrs. last birthda 49	ay) If Under 1 Year If Under 1 Year Amonths Days Hours		8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Magonyy) and			
72 hours after death with the Maryland "attran", or Items 23a or 28a-f show any al Examiner must be meiffied at once.	Director	Maryland Calvert  10e. Street and Number 4875 St. Leonard Road  11. Marital Status 1 v Never Married 2 Married  Calvert  12. Was Decedent E Armed Forces?	ever in U.S.	Leonard  10f. Zip Code  20685  3. Was Decedent of Hispanic Origin Yes, specify Cuban, Mexican,	jin? ( Specify Yes or No-	10d. Inside City Limits 1 Yes 2 No  Og. Citizen of What Country? USA  14. Race - American Indian, Black, White, etc.			
5-0036 led within 72 hours after de Hygiene. other than "natural", or i	mpleted by	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade comp. Elementary/Secondary (0-12)  10  College (1-4 or 5-10)	oleted) 16a. De	1 Yes 2 X No specify: cedent's Usual Occupation (Give ring most of working life. DO NOT  Landscaper	use retired)	16b. Kind of Business,	ack Industry		
21215-0036 uld be filed within 7 Mental Hygiene, marked other than c event, the Medica	a	17. Father's Name (First, Middle, Last) $F  rank$ 19a. Informant's Name/Relationship (Type, Print )	Harris	18.Mother Vic		Broot			
ore, MD es I and 2 sho of Health and If item 27 is ther tranmati		Agnes Brook/sister  20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State	20b. Place of C	43 Elder Oaks Disposition (Name of cemetery, or other place) politan Crem.	Blvd. #6		e, MD20716 r Town, State		
Baltimore, permit. Pages I a Department of He Important: If ite	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee  Madep G. Sewell		22. Name and Address of Facility 1451 Dares Be					
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):							
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the consected of the cons							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	by Physician/Medical	by Physician/Medical	Physiciar	UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  AMENDED  23c. If yes, outcom 1 Live birth 4 Pregnant at t 9 Unknown  contributing to death	2 ime of death 5	Fetal death 3 Ectopic Other (Specify)  n the underlying cause given in Pa	art I. 23e. Did to	bbacco use contribute to 2 No 3 Pro	Day Year
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Division of Vit To the Hospital or Attending Physic within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dire	Certification: To E	1 V Yes 2 No Inpatier  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	y 28b. Tin	patient 3 DOA Other 4  me of Injury 28c. Injury at Work 1 Yes 2  n, street, factory, office building, et	? 28d. Describe	Residence 6 Other			
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		Suicide 6 Could not be determined (Specify)  29a. Certifier Continue Deviation To the heat of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of			or Town, S	itate)	ural Route Number, City		
To the H within 24 To the F complete	Medical	(Check only one) 2					he cause(s)		
		30. Name and address of person who completed cause of de Susan Hogan MD. Assistant Medical Ex	aminer 111	Penn Street, Baltimore, I	MD 21201				
St Regis	ate rar	31. Date filed (Month, Day, Year) 32. Figistrar MAY 1 1 2006	s Signatur	Sparke					

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** EDITH KATHLEEN HARRISON MAY 2006 6 1700 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7882 PEA NECK ROAD TALBOT ST. MICHAELS If Under 1 Year If Under 24 Hrs. 8. Date of Birth OCT 7, 1913 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 ☐ M 2 👿 F 92 VIRGINIA 215-22-4664 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County iral', or Itams 23a or 28e-f show Examiner must be notified at 1 ☐ Yes 2X No MD TALBOT TILGHMAN Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4871 FAIRBANK ROAD 21671 USA Completed by Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: Specify: WHITE 3 Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic avant, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) marked other than 10 Ò HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 12 should be fi and Mental F is marked of RUFUS LIPSCOMB JENNETTE WHITEHEAD ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: If itam 27 is s JOHN HARRISON/SON 7882 PEA NECK ROAD, ST. MICHAELS, MD 21663 othar t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Bemoval from State 9 permit. Page Department of Important: If eny injury or once. TILGHMAN MEMORIAL CEM. 5/10/2006 1 4 ☐ Donation 5 ☐ Other (Specify) TILGHMAN, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final METASTATIC LANCER PRIMARY **Physician** MNENDRON disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, I ay leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medlcal the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autonsy performed' 1 Yes 2 🗌 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SONS HOME P 1 🗌 Yes 2 🗷 No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death Injury at Work? 28d. Describe how injury occurred Certification: 28c. After or Attanding 5 Pending investigation 1 Matural 1 🗌 Yes 2 No 2 Accident Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 THomicide within 24 hours a To the Funeral C 1 [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0 5/9/06 The me my Thur D0057908 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) 8205. TARBOT PATTEROSON ST. MICHAELS OND (COBEN 1°0°2006 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** RICKEY CORNELL HYNSON 05 2006 9:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CORCISO HILLS NURSING HOME CENTREVILLE

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **OUEEN ANNES** 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 12 M 2□F Yrs. Director 212-66-1600 Mar. 29, 1954 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Queen Annes <u>Grasonville</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 Fox Run 21638 Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 (MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No þ Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Queen Annes County Elementary/Secondary (0-12) College (1-4or 5+) Custodian Board of Education land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis S. Wilmer Peggy Hynson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara R. Hynson / Wife 107 Fox Run, Grasonville, Maryland 21638 imore, 20b. Place of Disposition (Name of cometery, crematory or other place)
Maryland 20a. Method of Disposition 20c. Location - City or Town, State Department of I 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ° 4 ☐ Donation 5 Other (Specify) 05-15-2006 Hurlock, Maryland Veterans Cemetery alti f Funeral Service Licensee 22. Name and Address of Facility Paunie Smith funeral Home 426 Dover Street, Easton, Maryland 21601 Drince 23a. Putt Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC **Physician** SMALL ROUND BLUE CELL TUMBE /Medical Due to (or as a consequence of): Examiner KENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): RESPIRATORI that initiated events resulting in death) Last Due to (or as a consequence of): 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 WNo Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ YPERTENSTON 1 Yes 2 No 3 Probably 4 Unknown Completed PERLIPTOGMAA 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? DUT 2 BNo 1 ☐ Yes 2 No Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ∰ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Watural death. investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 22 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date sighed (Month, Day, Year) MC 30. Name and address of person who completed cause of death (Item 23) (Type, Print) Ciganek M.D. F. 31. Date filed (Month, Day, Year) State MAY 0 9 2006

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and the	Physicia /Medic	เท	1. Decedent's Name (First, Middle, Last)  John F. Hines Jr.		2. Date of Death Month 05 04	Day Year	3. Time of Death 0015			
	Examin		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical	4c. County of Death Anne Arundel						
	Funeral Director		5. Social Security Number  220 12 1447  Usual Residence of Decedent  6. Sex  M 2 F  7. Age (In yrs. last birthda 82 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 06 4 19	ear) 9. Birth Cou	place (State or Foreign intry) Cyland			
Maryland	Maryland -f show		10a. State 10b. County 10c. City, Town or	Location evensville			10d. Inside City Limits 1 Yes 2 □ No			
h with the	23a or 28a lat be noti	<u> </u>	10e. Street and Number  Lott's Road	10f. Zip Code 21666		. Citizen of What Cou	intry?			
<b>036</b> ours after deat	al', or items ? Exeminer out	by Fur	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 X Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp ff Yes, specify Cuban, Mexican, Puerto     □ Yes 2 No Specify:	ecrfy Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	ican Indian, , etc. Black			
21215-0036	if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic svent, the Medical Exportmentment by mutified at	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work a. DO NOT use retired)  Chanic	king	b. Kind of Business/I	ndustry			
Maryland	Mental Hyg arked othe atic svent,	To Be C	17. Father's Name (First, Middle, Last)  John Hines Sr.	Add	dell Con	ley				
, Mar	alth and n 27 is m er traum		Taresa V. Hymun(daught)	Lott's Road Ste	evensvil	le, Md 2	21666			
Baltimore,	2 = 2		20a. M. A. G. G. G. G. G. G. G. G. G. G. G. G. G.	sposition (Name of crematory or other place) nd Veteran's5/1(		c. Location - City or 1 eluh, Ma				
Balti	Departmen Important: any injury once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Eric L. Dashiel	322 East l Eas	Ave. ton, Md.				
E	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):							
Records, P.O. Box 68760,	been signed by the attending physicien and should be detached for use as the burial-transit	Physician/Medical E		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deli	Day Year			
rds, F	n signed uld be de	ρ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		cco use contribute to the cause of death?  2 No 3 Probably 4 Munknown				
Reco	8 5 6	Completed			24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of 2 No			
Division of Vital Records,	this aldi	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	atient 3 DOA Cther: 4 Nursing Hole of Work?  M 1 Yes 2 No	ent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) of 28c. Injury at Work?					
Divis	s after de al Directi ed in by t	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town,	et and Number or Ru State)	ral Route Number,			
H et	to the mospinal of Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the tuner	Medicai	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, do not be desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the desired in the	or investigation, in my opinion, death occur	rred at the time, date		to the cause(s)			
	Within 3		Joen Bah, 140	D46052		5/4/00				
( 1	VA)		30. Name and address of person who completed cause of death (flem 23a) (Ty  200   Medical  31. Date filed (Month, Day, Year)  32. Registrar's Signature	al Parhway anna	bolis, MI	P				
	Sta Regist		31. Date filed (Month, Day, Year)  32. Registrar's Signature	Acres 10						

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Na ANETTE ARRIS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Baltimore Sinai Bultimore If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ff Under 1 Year Months Days Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 🗆 M 2 XF 219-34 Director Usual Residence of Decedent wode 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examinar must be notified at Completed by Funeral Director DOM ERSET 1ANORIX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9010 21836 ILLLARD LONG Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 🥕 No Baltimore, Maryland 21215-0036 Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) 0 KER17. Father's Name (First, Middle, Last) Be ERBERT TRMWOOD 2 LULA 19a. Informant's Name/Relationship (Type, Print) 9010-MIL HARRIS - HUSBARD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Depertment of H
Important: if ite
ony injury or of 1 Burial 2 □ Cremation 3 □ Removal from State SAMUELWESLEYCH. 4 ☐ Donation 5 ☐ Other (Specify) 12/06 21. Signatura of Funeral Service Licensee, 22. Name and Address of Facility ENNIE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner signed by the attending physician and the detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an page 2 autopsy 1 Tes 25 Hospital or Attending Physician: After this certification Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospitaf: 1 ☐ Inpatient 2 (No Other: 1 Tes 2 X FR/Outpatient 3 DOA 4 Nursing Home 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. fnjury at Work? 28b. Time of Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death within 24 hours after des To the Funeral Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide 29a Certifier Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier License number of death (Item Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

BOZMAI 18. Mother's Name (First, Middle, Maiden Sumame) HOLDEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARD LONG ROAD, MANCKIN MD 21836 20c. Location - City or Town, State MANOKIN MD Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 0 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date sidned (Month, Day, Year) 2006 toward 21215

Year

7,006

USH

14. Race - American Indian, Black, White, etc.

BLAC

701

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month)

32. Resistrar's Signature

0 2008

			For State Ragistrar	State of I				of H	ealth a	ind Me	ental Hyg	Reg. No.	006	10	426
	Physici		1. Decedent's Name (First, Middle, Las	et)							2. Date of Dea Month	ith Day	Year	3. Time	e of Death
T _a	Physici /Medic		Eina Eimira narris							May	17			50 P ^M	
	Examin	er	4a. Fecility Name (If not institution, give			h = 7	**						ounty of Dea		
			Frederick Mem  5. Social Security Number 6. S			last birthday)	If Under		deri		3. Date of Birtl		reder		te or Foreign
	Funeral Director			Ом 2√7 F	88	Yrs.	Months	Days	Hours	Min.	B. Date of Birtl (Month, Day Feb. 19	Year) , 19	18 V	irgin	te or Foreign La
	rland ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. fnside	City Limits
	Mar-	ţō	Maryland Freder	ick		Myersv	ille						,	1 🗆 Y	es 2√ No
	3e or 28	al Director	10e. Street and Number 10742 Church Hill	Road			10f. Zip (	Code 2177	3			10g. Citize	on of What Co USA	ountry? *	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If itam 27 is marked other then "naturel", or items 23a or 28a-f show or other traumatic event, Ita Macical Examinational Leansilliad at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Deceded Armed Force 1 Tyes 2 If Yes, Give 4 Year or Date	∍s? □No X		Was Decede If Yes, speci 1 ☐ Yes 2	ify Cubai	spanic Orig n, Mexican Specify:	in? (Spec , Puerto R	ify Yes or No- ican, etc.)		I. Race - Ame Black, Whit ipecify: Wh		
21215-0036	n 72 hou "nature	Completed by	15. Decedent's Ec (Specify only highest gra			16a. Dece	dent's Usual kind of work DO NOT use	l Occupa k done d	ution uring most	of working	9	16b. Kind	d of Business	Industry	
12	withir ene. then	duc	Elementary/Secondary (0-12)	College (1-4	or 5+)	Secre		o romou,				Nava	l Rese	arch	
Maryland 2	d be filed antal Hyg ced other c event,	To Be C	17. Father's Name (First, Middle, Last) William Fry								First, Middle, a Frye	Maiden S	iumame)		
Z Z	shoul nd Me mark	1-	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rurai	Route Numbe	r, City or	Town, State,	Zip Code)	
	alth a		Jacquelyn Paulus	- daught	er	10742	Chur	ch E	lill F	Road,	Myers	ville	, Mary	land !	21773
Je,	of Hei		20a. Method of Disposition			Place of Dispo	matory or oti	her place	9)	Da			ation - City or		
Ē	Page nent c int: if		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		St.	Paul's	Luthe	eran	5	-22-2	2006	Myer	sville	, Mary	land
Jacquelyn Paulus – daughter  10742 Church Hill  20a. Method of Disposition  20b. Place of Disposition (Name of cometery, crematory or other place)  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Faricketts Funeral										n Stre		73			
760,	by Seath certificate be executed attending physicien and for use es the buriar-transit	ilcal Examiner	shock, befearl failufe. List only Immediate Cause (Finar disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (or c.	as a conseq	uence of):		Rive						Interval	Between nd Death
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rds, P.	quires that n signed t	by	Part II. Other significant conditions of	_	h but not res	ulting in the u	nderlying ca	iuse give	n in Part I.			es 2	ocontribute to	the cause obabiy 4	
Records,	ysician: The law requir is certificate has been si director, page 2 should	Completed									24a. Was autop	sy m <i>e</i> d?	death?	completion of	gs available of cause of
Vital		0	25. Was case referred to medical						26. Place	of Death	1 Yes		1 195	2 No	
<u>&gt;</u>	Physician: this certific ral director,	To B	examiner? 1 □ Yes 2 2 No	Hospital: 1 Inp	atient 2 🗆	ER/Outpatier	nt 3 DO	A Othe			e 5 □ Resid		☐Other (Spe	cify)	
ion of	ling Ph ). After th funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month,	njury Day Year)	28b. Time o Injury	f 28	Bc. Injury Work		28	3d. Describe h				
Division	el or Attendi el after death. I Director: A d in by the fu	Certification:	3 🗍 Suicide 6 🗎 Could not b. 4 🗍 Homicide determined	28e. Place of	fnjury - At he , etc. (Specif	ome, farm, str	reet, factory,	, office		28	3f. Location (S City or Tow		Number or Ri	ural Route N	lumber,
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam one)	ysician: To the be niner: On the basi and manner	s of examina	owledge, deat ition and/or in	h occurred a vestigation,	at the tim	e, date and pinion, deat	d place, ar	nd due to the o	ause(s) a date and p	nd manner as lace, and due	stated.	6 <b>e</b> (s)
	withir To th comp	N N	29b. Signature and title of certifier						number				signed (Mont	-	
			1 Gluz	けつ			D	000	179	51		05 -	19-2	2006	
	3		30. Name and address of person who SIBTE A. KAZN	completed cause	of death (ften	n 23a) (Type,	Print)	AVE	. FA	EDE	AICK.	WD	217	ol ·	
	Sta		31. Date filed (Month, Day, Year)	3 . Ring	istrar's Signa	ature .	ati j								
	Regist	rar	MAY 2 4 LUI	J0 1222	Set for	A CONTRACTOR AND A STATE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE	-(s) Ober								

State of Maryland / Department of Health and Mental Hygiene | Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 5:25 P. Reuben Isaac Harvey 18 2006 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs.

The Days Hours Min. 8. Date of Birth (Month, Day, You August 22 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months 1⊠M 2□ F 273-05-8217 89 1916 Ohío Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show ir then "neturel", or items 23a or 28e-f show the Medical Evantimer must be notified at 1 ☐ Yes 2 X No Director MD. Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12349 Huyett Lane 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status a filed within 72 hours after dual Hygiene.

other then "neturel", or Item Bleck, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 12 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ages 1 and 2 should be file nt of Health and Mental Hi :: If item 27 is marked oth Be Grace Snederker Asa Harvey ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7510 State Route 314 Mansfield, Ohio 44904 Richard Harvey/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If itel
any injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State 5/22/06 Shauck Cemetery Johnsville, Ohio ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. 17225 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) amun Physician ueno /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to animodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a noneequence of) Examiner The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: Hospital: 1 Yes 2 No 1 Inpatient 2 K ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident completely filled in by the after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel o within 24 hours aft To the Funerel Di 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of centile 0663233 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shahid Mahmood, MD. 580 Northern Ave. Hagerstown, Md. 21740 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 2 4 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Linda Blann Insley May 10 2006 11:45a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Dorchester General Hospital Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗗 F Months Days Hours Yrs. 80 Director 123-18-2848 New York Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or items 23s or 28s-1 show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Completed by Funeral Director MD Dorchester East New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1912 Academy St., Apt. 103 21631 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 215 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 N Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 licensed practical nurse state hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H. tent: If item 27 is marked others. Be Melvin R. Blann 2 Anna Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 i Christine Morganhaler 16 Barringer Road, Ilion, NY niece 13357 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State ö 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State permit. Page Depertment of Importent: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory | 5/11/06 Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. -k.B. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** septicemia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ongestive heart tailure Greatmany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Die to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death signed by the e 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, icate has been sign, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 No Hospital or Attending Physician: After this certifice funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 @Natural Injury 5 Pending death. 1 Yes 2 No investigation 2 Accident within 24 hours efter deatl To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) xan 140059973 a d address of person who completed cause of death (Item 23a) (Type, Print) 100 Bramble St ambridge JOHNSON 31. Date filed (Month, Day, Year) 32 Registrar's Signature 1 1 2006 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician 08 Gregory W. Jeter 05 200610:30 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Min. North Days Hours Min. 01/31/1954 6. Sex 1 ⅔ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Pennsylvania **Funeral** 52 Yrs. 579-72-2037 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. important: if Item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Prince George's Landover 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20785 533 Pacer Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Black Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Postal Service Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Francis Rollins Robert Jeter ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 533 Pacer Drive Landover, MD 20785 Edna Jeter/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Resurrection Cemetery05/13/2006 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 4308 Suitland Road Suitland, MD 20746 Approximate Interval Between Onset and Death 23a. Part1. The rise disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS **Physician** one month resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, backing to immediate cause. Enter Underlying Cause (Disease or injury ibite to (or as a nonsequence of) Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy Month Day Y*e*ar 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Circhosis, Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown UICEL DISEASE, Ascites 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 1 Yes 21 No 2 No or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 I I inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 PNatural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature a 29d. Date signed (Month, Day, Year) D61007 30. Name and address o empleted cause of death (Item 23a) (Type, Print) 831 E. University Blud #25 Silver Spring, Maryland 20903 Kenneth Khandagle 31. Date filed (Month, Day, Year) State Registrar 1 2006

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** Rhoda Claire Jackson 2114 2006 MA451 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner George's 1005,27 ta heverli If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Ian. 27, 1 Birthplace (State or Foreign Country) 6. 5ex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 1 F 58 Months Days Hours 578-64-2440 1948 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show way lolury or other traumatic svent, the Medical Examinational be notified at once. 10a. State 10b. County Temple Hills 1 X Yes 2 ☐ No Maryland Prince George Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5901 St. Moritz Drive 20748 United States Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ent: If Item 27 is marked other than *natural', or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: **Black** ፩ 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Child Care Director Child Care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert L. Dean Jewell Cobb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Scott/Daughter 5901 St. Moritz Dr., Temple Hills, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery May 13, 2006 Suitland, MD 4 □ Donation 5 □ Other (Specify) Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747 21. Signature of Funeral Service Liceruse 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Atheroscherotic CArdieVASCU **Physician** /Medical Examiner Securitally list moditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent prechant in the past 12 menths? 3 Ectopic pregnancy Day Month Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 1 Yes 2 No ပို 5 Residence 6 Other (Specify) Director: After this in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person ocompleted cause of death (Item 23a) (Type, Print) 3001 Hos State Registrar

			State of Maryland / Dep	artment of Health and M rtificate of Death		one 006	16431
	Physicia	e i	Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year	3. Time of Death
	/Medic	al	SYRLYRVIAN HENRY JEFFRIES  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	MAY	09, 200 4c. County of Death	
	Examin	er	CLINTON NURSING HOME	CLINTON		PRINCE	
	Funeral		5. Social Security Number 6. Sex 7. Age ( <i>In yrs. last birthday</i> 1. Text 2 F 70 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.	8. Date of Birth (Month, Day, Y) 11-10-19	9. Birth	nplace (State or Foreign untry) INGTON DC
	Director		579-46-5636 1 XM 2 F 70 Yrs.  Usual Residence of Decedent		11-10-19.	WASIII	INGTON DC
	nytand	_	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits  XXYes 2 □ No
	the Ma 28e-1	ecto	MD PRINCE GEORGE'S CLINTON  10e. Street and Number	10f. Zip Code	100	. Citizen of What Co	
	3s or	al Dir	6905 DANFORD DRIVE	20735	U	SA	
000	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23s or 28s-1 ahow other traumatic avent, it s Modeal Examinational boundlined at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes XX No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: BLA	e, etc.
5	72 hou	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing 16	b. Kind of Business/l	Industry
7	within iene. than '	omp	Elementary/Secondary (0-12) College (1-4or 5+) SALES	,		PRIVATE	
םם	al Hyg f other vant,	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	iden Sumame)	
2	a Ment narked natic s	To	SYRLYRVIAN JEFFRIES  19a. Informant's Name/Relationship (Type, Print)  19b. Mai	LARRINDA		City or Town. State. 2	Zip Code)
2	nd 2 sh ulth and 27 is n r traun		Tod. Illionitation to anti-	CROSSLINK RD. RAI		•	
more,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 20b. Place of Disposition cometery, cre	osition (Name of ematory or other place)	Date 20	c. Location - City or UITLAND, MI	
Baillmor	permit. Departm Importa any inju			MARSHALL FOR FUNERAL 4308 SUITLAND ROAD		MARYLAND, ID, MD 207	
1	Pnysician		23a. Plant. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final LUNG CANCER	nter the mode of dying, such as cardiac	or respiratory arres		Approximate Interval Between Onset and Death 4 YEARS
h	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
	<u>.</u>	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)				
	aath certificate be executed attending physician and for use as the burial-transit	Examiner	Cause (Disease or injuty that initiated events c. Due to (or as a consequence of):				
8/60,	e be ex	dical E	d				
٥	ntificat ing phy e as th	Medi	IF FEMALE:				= = = = = = = = = = = = = = = = = = = =
O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	hysiclan/Me	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	23d. Date of deli Month	ivery Day Year		
٦.	res that ti signed by be detac	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to	the cause of death?
Records,	The law requires that tte has been signed b age 2 should be dete	Completed			24a. Was an autopsy	24b Were au	utopsy findings available completion of cause of
r m	10			OC Binn of Doc	performe  1 Yes XX	No 1 □ Yes	2 No
Vital	ysician: is certific director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes ※※ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati				cify)
o uc	ding Ph. h. After th funeral	lon: T	27. Manner of Death  XXNatural 5 ☐ Pending (Month, Day Year)  28. Date of Injury (Month, Day Year)  28. Time Injury	of 28c. Injury at	28d. Describe how		
Division of	l or Attanding Physician: after death. Director: After this certific I in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)		28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical Ce	29a. Certifier XXX Certifying Physician: To the best of my knowledge, der (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.				
	ro the within 2 fo the comple	Med	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Monti	h, Day, Year)
/			1 msin mo.	D45365		MAY 12, 20	006
R	4)		30. Name and address of person who completed cause of death (Item 23a) (Type M. SIDAROUS, MD 11701 LIVINGSTON RD.	#111 FT. WASHINGT	ON, MD 20	)744	
	St Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 1 2 2006  S2. Registrar's Signature	Lo			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** JONES MAY 4 2006 6:52 P MAE T.TDA /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Clinton Southern Maryland Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🙀 F Yrs. 83 578-26-8729 April 14 1923 North Carolina Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. fnside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Itams 23a or 28a-f shov the Medical Examiner must be nutified at 1X Yes 2 □ No PRINCE GEORGE'S UPPER MARLBORO Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20772 9415 CASTLE DRIVE Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: Specify þ 3 XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Efementary/Secondary (0-12) Colfege (1-4or 5+) PRIVATE BOOKKEEPER 12th 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked othe eny lipity or other traumatic event, page. 17. Father's Name (First, Middle, Last) Be MAMMIE HOLLAND ၉ UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 9415 CASTLE DRIVE UPPER MARLBORO, MARYLAND YVONNE COLE/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 5/12/2006 LAUREL, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND NATIONAL 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J. B.JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurer. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner MINIME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed es the burial-transit onono Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23d. Date of deliver 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy detached for Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 9 Dunknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 🗌 Yes 2 XNo 2 🕱 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1 🗌 Inpatient 3 DOA 2 X ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 🙀 Natural 5 Pending s after de. 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funeral D completely filled in To the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and monner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 0041580 May 6 2006 of person who completed cause of death (Item 23a) (Type, Print) SCOTT KELSO M.D. 7503 SURRATTS ROAD CLINTON, MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 0 2006 Registrar

		-	For State Registrar	itate of Marylan		artment of F			iene 006	16433
	Physicia	ın	1. Decedent's Name (First, Middle, Last) Teresa Reaud Jareed					2. Date of Death Month May 8,	Day Year	3. Time of Death 0049 M
	/Medic Examin	er	4a. Facility Name (If not institution, give stre Montgomery General I			4b. City, Town, o	r Location of Dea	th	4c. County of Dea	
*	Funeral Director		203-72-2017	7. Age (In yrs. 61	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) C	rthplace (State or Foreign Country) Cuba
	Maryland f show	ō	Usual Residence of Decedent  10a. State  Maryland  Montgome	ŧ	y, Town or Lo Silver	cation Spring				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the f a or 28a- be notif	Funeral Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What C	-
	ath 23	a	3210 North Leisure V			20902			United S	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depirtment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23s or 28s-1 show any injury or other traumatic event, the Madical Examinar must be neitlified at once.	by Fune	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Was Decedent Ever in U Armed Forces? 1 _Yes _ 2 \( \tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tide{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\		Was Decedent of H f Yes, specify Cuba 1 X Yes 2 No	Ispanic Origin? (: an, Mexican, Puel Specify: Ct	Specify Yes or No- no Rican, etc.)  1ban	14. Race - Am Black, Wh Specify: W	ite, etc.
Maryland 21215-0036	thin 72 hou e. en "nature Madical E	Completed	15. Decedent's Educat (Specify only highest grade co		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo d)	orking	16b. Kind of Business	s/industry
2	gien gien	5		4	Micr	obiologis	t	]	Federal Go	vernment
ıland	uld be file Mental Hy rked oth	Be	17. Father's Name (First, Middle, Last)  Angel Reaud					_{ime (First, Middle, M} Licia Cast	·	
ary	sho and h ama		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailir	ng Address (Street	and Number or F	lural Route Number,	City or Town, State,	Zip Code)
≥	and 2 salth a n 27 f		Michael A. Jareed/ S	on	2810	Airdrie .	Avenue,	Abingdon,	Maryland	21009
ore	S S S S S S S S S S S S S S S S S S S		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rem		emetery, crer	sition (Name of natory or other place	(e)	Date	20c. Location - City o	r Town, State
Ĕ	Pag ment ant: f		4 Donation 5 Other (Specify)	1 11	ontgom remato	rium, Inc	. May	11, 2006		Maryland
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service Licenses	M01	433 R	Name and Addre ockville, ockville,	ss of Facility Ro Inc. 30 Marylar	obert A. 1 00 West Mo nd 20850-2	Pumphrey F ontgomery 2805	uneral Home/ Avenue
	Physician /Medical		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one disease or condition resulting in death)	ause on each line.				cular D		Approximate Interval Between Onset and Death
u	Examiner			H. norton	Linn					1000
07	- A - B	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):	·				years
	cuted nd ransit	Examiner	that initiated events C.	,						
8760,	ate be executed hysician and the burial-transit	Ical	resulting in death) Last	Due to (or as a conseq	uence of):					
P.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23c. in the past 12 months? 1 □ Yes 25 No 9 □ Unknown	If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	slivery Day Year
	§ 20 g	by	Part II. Other significant conditions contrib	outing to death but not res	ulting in the u	nderlying cause giv	en in Part I.			to the cause of death?  Probably 4 □Unknown
Vital Records	The law ate has b page 2 s	Completed						24a. Was ar autopsy perform 1 \sum Yes 2	y prior to	
/ita	ysician: This certificate	Be	25. Was case referred to medical examiner?					ath (Check only one	е)	
of V	<u>v</u> ∞ <u>v</u>	ဥ	1 X ves 2 □ No	→ 1 ☐ Inpatient 2 2	R/Outpatier		4 🗀 Nursing	Home 5 ☐ Reside	nce 6 ☐Other (Spe	ecify)
n c		on:	1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe ho	w injury occurred	
isic	Attending r death.  ctor: After by the fune	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he	omo form et		Yes 2 □No	29f Location (St	reet and Number or F	Pural Planta Number
Division	spital or Attendious after deathing after deathing after deathing in Director:	Certification:	4 Homicide determined	building, etc. (Specif	(y) 	•		City or Town	, State)	
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical	(Check only 2 Medical Examiner one)	en: To the best of my kno : On the basis of examina and manner stated.	wledge, deat tion and/or in	vestigation, in my o	pinion, death occ	urred at the time, da	ate and place, and du	e to the cause(s)
<b>\</b>	4		29b. Signature and title of certifier	lan MD		DOG:			9d. Date signed (Mon	
•	208		30. Name and address of person who comp	leted gause of death (Iter	n 23a) (Type.	Print)	0 70-1		Nay 8, 20 20832	JV 6
			Phyllis Nicholson	RIOI Prince	Phillin	Drive	olney n	laruland :	20831	
	Sta		30. Name and address of person who comp Phyllis Nicholson 31. Date filed (Month, Day, Year)  WAY 1 0 200	32. Rigistrar's Signa	ature	ande	11	·		
1	Registr									

		1	For State Registrar	State of M	aryland /	-	rtment tificate			and Me		giene Reg. No.	006	164	3 4
			Decedent's Name (First, Middle	e, Last)							2. Date of De	ath Day	Year	3. Time of De	eath
	Physicia		EDNA	JENNE	TTA		JAC	KS01	V		May	17,	2006	11:25	$\mathbf{A}^{M}$
1	/Medic Examin		4a. Facility Name (If not institution	n, give street and number	)		4b. City, 7	Town, or	Location o	of Death		4c. Co	ounty of Death		
16.7			4054 Old	York Road					onkt				Harf		
F	Funeral Director		5. Social Security Number 202–22–6430	6. Sex 7. A 1 ☐ M 2 <b>X</b> F	ge (In yrs. last i	Yrs.	If Under Months	1 Year Days	Hours	24 Hrs. Min.	8. Date of Bir (Month, Di 8/23/	1920	Cou	place (State or F ntry) ryland	oreign
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itema 23a or 28a-f show int, the Madical Everta or mint be notified at	Director		arford	10c. City, To	own or Lo			Мо	nkto	on	10-000		1   Yes 2	
	를 다 다 하 다 하 다 다 다 다 다 다 다 다 다 다 다 다 다 다	Olre	10e. Street and Number		_		10f. Zip	Code	07				n of What Cou		
	ath w	ra	4054 Old	York Roa		1.0				111	- dr. V-s or Al		ted S		
36	irs after deat if, or items?	by Funeral	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	If You Give	? [No		Was Deced f Yes, spec		Specify:	gin? (Spe n, Puerto f	cify Yes or No Rican, etc.)		Black, White		
Maryland 21215-0036	in 72 hou in "natura Vedical E	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	nt's Education st grade completed)		(Give	dent's Usua kind of wor DO NOT us	k done d	uring mosi	t of workin	ng	16b. Kind	of Business/li	ndustry	
212	filed withi Hygiene. other than	E O	5	0			Ho	user	wife			l	Hom	•	
land	permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than 'amy injury or other traumatic event, than Manance.	To Be (	17. Father's Name (First, Middle, Ralph	Luther	S	Sutt	on			ers Name Edit	(First, Middle 5h	e, Maiden Si		Troyer	
ary	shot ind N ma		19a. Informant's Name/Relations	ship (Type, Print)	1	9b. Mailir	ng Address	(Street a	and Numbe	er or Rura	i Route Numb	per, City or 7	own, State, Zi	Code)211	11
	and 2 alth a 27 to er tra		Arlene Hamme	rstein/Da		-	Old						Mary		
ore	of He of He of He of Item		20a. Method of Disposition 1 M Burial 2 ☐ Cremation	3 □Removal from Stat	20b. Place ceme				-		ate		tion - City or T		
Ë	Pages ment of thant: if its lary or o		4 □Donation 5 □ Other (S	Specify)	Wesl									Maryla	
Baltimore,	Dependi Dependi Importi any inj once.		21. Signature of Funeral Strvice	Lifensee	سللغ	10.0	2. Name an			00				arylan	.d
	205 # 0		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that caus t only one cause onleach	ed the death. D		ter the mod	e of dying	g, such as	cardiac o	r respiratory a		Home	Approximate Interval Betwee Onset and De	
760,	Physician /Medical Examiner and parial-transit	cal Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or a	s a consequent	ce of):	n es	art	Fa	11014				7 gew	3
O. Box 68	The law requires that the death certificate be exite has been signed by the ettending physicien bage 2 should be detached for use as the buriar	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal de at time of death	ath 3	□Ectopic pr □ Other (sp					23	d. Date of deli Month	very Day Ye	ar
٥	uires that signed b id be deta	þ	Part II. Other significant condit	ions contributing to death	-11	ng in the u	inderlying c	ause give	en in Part I	l. 		tobacco use	,	the cause of dea	
Records,		Completed	Kyperli	pidemia	<u>-</u>						24a. Wa auto peri 1  Yes	opsy formed?	24b. Were autoprior to death?	opsy findings avoid ompletion of cau	railable ise of
ta	an: rtifica tor, p	0	25. Was case referred to medica	al					26. Place	e of Death	Check only	100			
Division of Vital	ding Physician: The lav h. After this certificate has funeral director, page 2	lon: To B	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pend	Hospital: 1 Inpa  28a. Date of In  (Month, I		/Outpatie b. Time o Injury		28c. Injun	4 🗀 140		me 5 Res 28d. Describe		Other (Spec	ify)	-
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could	not be 28e. Place of	njury - At home etc. (Specify)	e, farm, st	reet, factor					(Street and own, State)	Number or Ru	ral Route Numbe	er,
	e Hospita 24 hours e Funeral etely filled	edical C		ing Physicien: To the be I Examiner: On the basis and manner	of examination										
	Vithin of the omple	₩ We	29b. Signature and title of certifi	ier	4	1			e number				signed (Month		
	C > F 0		1 Trade	- 4 Wales	21	1/		D3	420	8		51	118/20	OG	
	10		30. Name and address of person	n who completed cause of	f death (Item 23	Sa) (Type,	Print)	svice	E RI	o, Ux	RRET	75014	E M	06	1
	St Regist	ate trar	31. Date filed (Month, Day, Yea MAY 2 4 2	006 32. Regi	strar's Gignatur	park	V			,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death Rag. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician atheRINE 25 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S GENERAL HOSPITAL TAKOMA PARK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB 27, 1921 9. Birthplace (State or Foreign Country) WEST VIRGINIA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2X F Yrs 235-14-7195 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ahow f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Itema 23a or 28a-1 ahov other traumatic event, the Madical Examinar must be notified at **Funeral Director** BEL ALTON CHARLES MARYLAND the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20611 U.S.A. 9010 BOYLE DRIVE death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after and thealth and Mental Hygiene. 1 ☐ Yes XIXNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖔 No Specify Specify: Completed by WHITE 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN UNKNOWN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9010 BOYLE DR., BEL ALTON, MD 20611 SAMUEL L. JACKSON-HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition to = 1 

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. LINCOLN CEMETERY 5-1-06 SUITLAND, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses M0047 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. PLATA, MARYLAND mode of dying, such as cardiac or respira 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LNTRACEREBRA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical as the attending I 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the ch detached 9 Unknown 9 Unknow ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 1 Yes 2 No Hospitel or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1x Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 28c. Injury at Work? 27. Manner of Death ate of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural fell et back door April 17, 2006 WAKNOWN 1 🗌 Yes 2 X Accident home 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) (2000 much Route 4 | Homicide home Bel Alton, Mary land 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cai (Check only one) To the within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

4

DHMH 17 Rev 1/2001

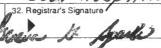
State Registrar

31. Date filed (Month, Day, Year)

MAY 2. 4.2006

Name and address of person

a



who completed cause of death (Item 23a) (Type,

ORIGINAL

Jeffry John Brigham Kershner

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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		Registrar	Cen	ificate o	Deam			Reg. No.	400	0 1370
Physici fedical Exam		Decedent's Name (First, Middle, Last)  Toffrag Tohn Decidence V	omahnom				2. Date of D Month	Day	Year	3 Time of Death 0030 hrs
Contract Exami	Hei	Jeffry John Brigham K  4a. Facility Name (if not institution, give street and n	_		4b. City, Town, o	or Location o	May 19,		ounty of Death	
		Baltimore Washington Medical Cent			Glen Burni			Ann	ne Arundel	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Ye	ar If Unde	r 24Hrs. 8. Date of	Birth(MM/DD/	/YYYY) 9. Bir	rthplace (State of ngto
Director		220–56–5297   1×M 2 F	54	Yn	Months Da	ys Hours	Min. Nov.	28,195	51 Foreig	ountry) D.C.
		Usual Residence of Decedent	1							
, any		10a. State 10b. County		Town or Loca						10d Inside City Limits
Maryland 28a-f show any d at once.	5	Maryland Anne Arundel		Croft	on					1 Yes 2 X No
Maryl 28a-1 d at o	Director	10e. Street and Number 1715 Foxdale Court			10f. Zip Code			10g. Citizen	of What Cou	ntry?
th the Maryland 23a or 28a-f sho notified at once.						1114			USA	
th wit ems 2 t be n	Funeral	11. Marital Status 1 Never Married 2 X Married Armed I	cedent Ever in U.S Forces?				in? (Specify Yes or Puerto Rican, etc.)	No- 14.	. Race - Ameri White, etc.	ican Indian, Black,
er dea	F	1 Yes	2 X No		Yes 2X N	o coocifu:			Wh	nite
hours afte 'natural'', Examiner	b	Widowed 4 Divorced If Yes, Give Yes  15. Decedent's Education (Specify only highest gra		16a. Decede			kind of work done		ecify: VVI	
72 hou	Completed		1-4 or 5+)		nost of working lif					,
036 ithin 72 ne. r than Ledical	ď	12th		Mar	nager			Tel	Lephone	e Company
5-00 led with Hygiene other		17. Father's Name (First, Middle, Last)				18. Mother	s Name (First, Middle	e, Maiden Sur	rname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	John Willis Kershner					Lorraine			
D 2 Should and M is ma	To	19a. Informant's Name/Relationship (Type, Print ) Melody Kershner/ Wife					ber or Rural Route N			, Zip Code)
, MD and 2 sho ealth and em 27 is raumati		20a. Method of Disposition	20b. PI		sition (Name of c		Date	•	ation - City or	Town State
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mensel Hygiera in Propertment of Health and Mensel Hygiera in Engoveriar: If item 27 is marked other than "natural", or items 23a or 28a-f She injury or other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 X Cremation 3 Removal	from State cr	ematory or o		,	5-21-06		•	Maryland
tim trant rtant y or o		4 Donation 5 Other Specify: 21. Signature of Juneral Service Licensee	, na		Name and Address	os of Engility				
Balt permit. Departs Import		21. Signatore di Vineral Service Elicerisee					George F Island Rd	. Kala	ıs Fune	eral Home
Physician		23a Part I. Enter the disease, or complications that	caused the death, I							Approximate Interval
/Medical		failure. List only one cause on each line  Immediate Cause (Final disease a. Atheroscle	erotic Cardiova	scular Dis	sease					Between Onset and Death
Examiner			a consequence of)							
	_	Sequentially list conditions, b.								
	ine	cause. Enter Underlying Cause	a consequence of):	:						
t	Examiner	(Disease of injuly that initiated	a consequence of):							
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death cytificate be executed releath. After this certificate has been signed by the attending physician and by the thineral director, page 2 should be detached for use as the burial - transit		d.	7 0	055	5 01 00					-
O, be ex sician	ar/Medical		7 per fl		5-24-06	vt vt				
68760, ertificate be ding physici e as the buri	N/S	23b. Was decedent pregnant in the	, outcome of pregna birth	·	etal death 3	Ectopic	: pregnancy		ate of delivery onth E	y Day <b>Ye</b> ar
X 6 th cert tendir	icia	past 12 months?	nant at time of dea	th =	ther (Specify)		, ,	0		
Box ie death of the atter	Physicia	1 Yes 2 No 9 Unknown 9 Unkn						_		
y, P.O. Box 6 irres that the death cgr signed by the attendi the detached for use a	by P	Part II. Other significant conditions contributing	to death but not res	sulting in the	underlying cause	given in Pa				the cause of death?
S, F quires en sign ald be	pe			-						,
ords aw, requi as been 2 should	Completed				-		aut	topsy formed?		utopsy findings available completion of cause of
Rec The 1 icate 1 page	Son						1 🗸 Ye	s 2 No	1 Ye	es 2 No
tal   cian: certifi ector,	Be (	25. Was case referred to medical examiner?				Other	(Check only one)			
Division of Vital Records, tal or Attending Physician: The law, require as after death.  Juredors. After this certificate has been si led in by the fluereld director, page 2 should be	To	1 Yes 2 No		ER/Outpatier 28b. Time of		ury at Work	Nursing Home 5	Residence		r:
n of \index iding Phy. h. After tl	on:		e of Injury th, Day, Year)	Zob. Time of	1 200. 11	Yes 2	1	e how injury o	occurred	
Sion Aften Aften r deat ector by the	cati	2 Accident Investigation	ice of Injury - At hor	me farm stre	eet factory office			(Street and I	Number or Ru	ural Route Number, City
Division pital or Attent ours after death neral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify			July 1001079, 011100	ballaling, or	or Town		Number of Ru	narroate Namber, Oity
Hospi 14 hou Funer ely fil		29a Certifier 1 Certifying Physician: To the be	est of my knowledge	e, death occu	urred at the time,	date and pla	ice, and due to the ca	ause(s) and m	anner as star	ted
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis and manner	of examination and							
F. ₩ F. 0	Re	29b. Signature and title of certifier	stated		29c. Licer	nse number		29d. Date	e signed (Mo	nth, Day, Year)
		my him, mis			0.0	.M.E.		May 19	9, 2006	
		30. Name and address of person who completed car								
		Ling Li, MD Assistant Medical Exa			et, Baltimore	, MD 212	01			
S Regis	tate	31. Date filed ( <i>Month</i> , <i>Day</i> , Year) 32. MAY 2 4 2006	egistrar's Signatur	e A	nath p					
		MID ( 4) TO ( UUII 1 4/7	WESTAAN B ES	27 AND 23	STORY NO. OF THE PARTY NAMED IN					1

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Date of Month 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ALYCE MONABELLE KLINETOB 2006 May 5:30 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Crescent Cities Center Riverdale If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🖾 F Yrs. Director June 13, 1912 Pennsylvania 073-52-8876 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Maryla of Heath and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, item Medical Examinar must be muitined at 1 X Yes 2 □ No Director Maryland | Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4102 Farragut Street 20781 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 至 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be to nent of Health and Mental I John Vinton Mary Elizabeth Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Roberts - Daughter 4102 Farragut Street, Hyattsville, MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/11/2006 | Alexandria, Virginia Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause/on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Artemoscherop **Physician** 1Ruhi /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐NO the 9 Unknown 9 Unknown ፭ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Munknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 virsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral D 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 71852 Name and address of person who completed cause of death (Item 23a) (Type, Print) MS 4203 Queensbury Rel Hyattsville MS 20181 ORE 31. Date filed (Month, Day, Year) State MAY 1 1 2006 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Please Type or Print in	Black Indelible Ink.	<b>Ensure All Copies</b>	Are Legible

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.4	Physicia	in	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death 10:08PM
	/Medic Examin	er	Thomas Leo Kulczak  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death Prince G	h
	Funeral	100	Doctor's Community Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  163-22-9315  1 M 2 F 74  Yrs.	Lanham  If Under 1 Year	(Month, Day, Yea	ar) 9. Bint	hplace (State or Foreign untry)
	Director		163-22-9315 74 Yrs.  Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	pocation	June 8, 19	931 Penn	sylvania  10d. Inside City Limits
	deeth with the Maryland me 23a or 28a-f ehow	Director		Heights			t <b>y</b> ∏Yes 2 ☐ No
	with the		10e. Street and Number 8706 Edmonston Road	10f. Zip Code 20740	10g.	Citizen of What Co	untry?
		by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 ☒ Yes 2 □ No1 952 —	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert  1 ☐ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: W	
212-0030	filed within 72 hours after Hygiene. Hygiene. Ither then "naturel", or Ite and the Madical Exercite and, the Madical Exercite.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	rking 16b.	Safeway	Industry
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/au		To B	Jacob Kulczak	Franc	ces Zwolins	ski	
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Balti	permit. Pages Department of I Importent: If Its any injury or o ance.			2. Na <i>me</i> and Address of Facility Ga 4739 Baltimore Ave			
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	er the mode of dying, such as cardiad  The Fence High	c or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	Inferction	-		25 years
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O. Box 6	law requires that the death certificate be executed as been signed by the attending physicien end 2 should be detached for use as the burial-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of deli	very Day Year
rds, P	quires that n signed b	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.			the cause of death?
Division of Vital Records,	The ate h page	Completed			24a. Was an autopsy performed 1 Yes 2 ☑	death?	topsy findings available completion of cause of
Vita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Other	ath (Check only one)		
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Divis	el or Attendi s after death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St		iral Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place evestigation, in my opinion, death occurred.	e, and due to the cause urred at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	Vithii Vithii Comp	Ň	29b. Signature and title of certifier  My Wally #, My Dy	29c. License number D 0 0 4 2 6	84 5	Date signed (Month	h, Day, Year)
2	(12)	la	30. Name and address of person who completed cause of death (Item 23a) (Type, H. JAY ZWALLY H., MD \$1/10	Print) GOOD LUCK	CS. LAN	HAM, M	nd 20706
200	Sta Registi		31. Date filed (Month, Day, Year)  MAY 1 0 2006  Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** May 7, 2006 12:40 PM Delores Virginia Loukota /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 9507 Mazzoni Avenue Lanham II Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** 1 ☐ M 2 🖾 F 73 August 17,1932 577-42-4815 D.C Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Deperment of Heelih and Mental Hyslene.
Important: If item 27 is marked other than "natural", or Itama 23a or 28a-f ahow any injury or other traumatic event, the Modical Examination and once. 10b. County 1 TYes 2 □ No Director Lanham 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20706 9507 Mazzoni Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify þ White 3 ☐ Widowed 4 K Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Int'l Assoc. of Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Mach. & Aerospace Wkrs 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Virginia Powell Charles Elmer Ridgeway ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9040 Cabin Ct., Owings, MD 20736 Debbie Kruse - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/10/2006 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln F. H. Muan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3401 Bladensburg Rd., Brentwood, MD 20722 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Breast Cancer /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4XUnknown 1 ☐ Yes 2 ☐ No Certification; To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 🗋 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05/10/2006 30. Name and address of person who completed cause of death frem 23 (Type, Print) 10 14300 Gallart Fox lane #126 Bowie, MD 20716 Dr Richard Lilly 31. Date filed (Month, Day, Year, MAY 1 1 2006 32. Registrar's Signatu State Registrar

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			For State Registrar	State	of Marylar		artmen rtificat					giene ()	06	16440
	Dhuaisi		1. Decedent's Name (First, Middl	e, Last)							2. Date of De Month	ath Day	Year	3. Time of Death
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Importance of Health and Mental Hygiens Important: If item 27 is marked other than "neturel", or items 23e or 28e-f show amy injury or other treumetic event, the Madical Examinar must be multiled at once.	٦ ک	JAMES ALBERT S			19b. Maili	na Address	(Street a			EWMAN al Route Numb	er, City or Tow	n, State, Zip	Code)
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	hysicia /Medic	al	1. Decedent's Name (First, Middle, Elaine Louise	Lerman							2. Date of De Month May {	B, 2	006	3. Time of Death 0440 A ^M
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the Marylan	r 28a-f ehow rotified at	Irector	10a. State 10b. County  Maryland Montgor  10e. Street and Number	mery		ry, Town or Lo		Code				10g. Cit	izen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ No untry?
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aryiario should be file and Mental Hy	varked oth	To Be	17. Father's Name (First, Middle, L Hyman Doomchin						Lilli	an B	(First, Middle, uchsbau	ım.		
and 2 sh	m 27 is n her traun		19a. Informant's Name/Relationsh Richard Lerman/I		OOL 5	1490	4 Pine	y G		Ct.	N. Poto	omac	MD 208	378
Dailtimore, bermit. Peges 1 a Department of Hea	Importent: if Item 27 is marked or eny injury or other traumatic everance.		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 4 ☐ Donation 5 ☐ Other (Sp	pecify)	ta   C	Place of Dispo cemetery, crem esapeal	ke Cre	emate	ory	05/10		Be1	tsville,	MD
Dermit Depar	eny in		21. Signature of Funeral Service L  Beref + H	elite	MO1	251 Be	verly	L.	Heckr	otte	. P.A.	Cla:	P.O. Box rksville	784 MD 21029 Approximate
	sician edical miner		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a Uterine		er			, 3401140					Interval Between Onset and Death
Of VICAL DECOLUS, F.O. DOX 00700, Physicien: The law requires that the death certificate be executed	physicien and s the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	as a conseq									
the death certific	by the attending p tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	ıldeath 3⊑	Ectopic pre Other (spe						23d. Date of delik Month	very Day Year
quires that	gned e de	ρ	Part II, Other significant conditio	ns contributing to death	but not res	ulting in the u	nderlying car	use give	n in Part I.			obacco i		the cause of death?
The law requires t	this certificete hes been si ral director, page 2 should b	Completed									24a. Was autop perior 1 Yes	rmed?	prior to co	opsy findings available ompletion of cause of 2 No
V Ite	certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		150/0		Othe	_		(Check only o			
g .	After	ation: To	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investig			ER/Outpatien 28b. Time of Injury		c. Injury Work	4 🗆 140	2	8d. Describe h			My Hospice
tel or Atten	ei Director: ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	nod 1 288. Place of	Injury - At h etc. <i>(Specif</i>	ome, farm, str	eet, factory,	office		2	8f. Location (5 City or Tox			ral Route Number,
To the Hospitel	To the Funerel completely filled	Medical	29a. Certifier (Check only one)  1 X Certifying 2 Medical B	g Physician: To the be Examiner: On the basis and manner	of examina	wledge, death tion and/or in	vestigation, i	п ту ор	inion, deat	d place, a th occurre	nd due to the o d at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
		₹	29b. Signature and title olicery lier	$\sim$ r	20			License $635$	number		1		8, 2006	Day, Year)
20/	n		30. Name and address of person v					Po	ckvi1	1e 1	MD 2085	5.5	-	
, F	Sta Registr		31. Date filed (Month, Day, Year)	1 2006 32. Regi	grar's Signa	ature			<u>- :                                   </u>					

		For State Registrar	State	of Marylan	id / Depa		f Health	and M	ental Hyg	_	) 5	16442
		Decedent's Name (First, Middle,	Last)						2. Date of Deat	h		3. Time of Death
Physicia		Charlotte Fa	av Tewis						May 5,	2006	Year	10:45 P ^M
/Medic Examin	-	4a. Facility Name (If not institution,		umber)		4b. City, Tow	m, or Location	n of Death	4 , .	4c. County of	f Death	
- Zamin	<u>.</u>	115 Allnut Cour	t			Princ	e Fred	erick		Cal	vert	-
Funeral			6. Sex	7. Age (In yrs.		If Under 1 Y		er 24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign
Director		226-32-8195	1 □ M 2/201 F	7	6 Yrs.	Mortura	110013		Aug. 30,	1929 V	/irgi	
pu 🖈		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	ncation					1	0d. Inside City Limits
laryla sho	ក			100707								1 ☐ Yes 2 🖾 No
the N	ect	Maryland Calv  10e. Street and Number	ert		Prince	e Frede			1	0g. Citizen of Wi	nat Cour	itry?
death with the Maryland ms 23a or 28a-f show ricust be notified at	Funeral Director		+ ^-+	502		20678						
leath	era	115 Allnut Cour	12. Was De	cedent Ever in U	.S. 13.			Origin? (Spe	cify Yes or No- Rican, etc.)	United 1	- Americ	an Indian,
r Her o	F	1 Never Married 2 Marrie	Armed F	2 🔀 No					Rican, etc.)		, White,	
rel', o	by	3 ₩ Widowed 4 Divorced	If Yes, G Year or	iive Dates:		1⊡Yes 2∱∑	No Specif	y:		Specify:	Wh	ite
72 hc	Completed	15. Decedent's (Specify only highest	s Education	0	(Give	dent's Usual O	one during mo	ost of working	ng .	16b. Kind of Bus	iness/Ind	dustry
A I A I S-0030 d within 72 hours at giene. sr then "naturel", or the Medical Exem.	npl du	Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	DO NOT use re	etired)					
led w lygier her th		11	and		Home	maker	19 1401	har's Nama	/Circt Middle I	Own ]		
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y le	ဥ	19a. Informant's Name/Relationsh	in (Time Print)		10h Maili	an Addrona (St			Sirbaugh	City or Town, S	tate 7in	Codol
ire, Marylanid Z1Z13-0030 s 1 and 2 should be filed within 72 hours after death with the Marylan if Heath and Mental hygiene. If the and is marked other then "naturel", or items 23a or 28a-1 show other traumatic event. The Modical Examinar mount by motified at		Cindy Butler /			7					rmont, I		
than		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name o	of	•		20c. Location - C		
ages nt of t: Fit		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		n State Mo	Rest	haven	place)	Marz 0	2006	Emodoná.	-1-	Marrell and
Daltimor  permit. Pages: Department of the Important: If Ite eny injury or of		21. Signature of Funeral Service L		Me		Garder  Name and A						Maryland
Depa Impo		1/2/1/								Skkot ( derick,		
		231 Part1. Enter the diseas	complications that	caused the deat								Approximate
Physician		shock, or heart failure List of Immediate Cause (Final			. 1 .							Interval Between Onset and Death
/Medical		disease or condition resulting in death)		static C		ancer					+	2 months
Examiner		Convention line and disions	b. ———									
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		o (or as a conseq	quence of):							
acuter and trans	Examine	that initiated events	c									
/ <b>bU,</b> te be executed ysicien and se buriat-transit		resulting in death) Last	Due to	o (or as a conseq	quence of):							
<b>58/c</b> ifficate to g physical as the b	dicai		d									
	Completed by Physician/Med	IF FEMALE:	23c If yes o	utcome of pregna	ancv					22d Date	مر داد اد د	
BOX eath cer ettendir for use	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	at death 3[	☐Ectopic pregn ☐ Other (specif				23d. Date Mont		Day Year
the de	ystc	1 □ Yes 2 □ No 9 □ Unknown	9□ Unk		304117	_ Cition (special	,,		-10			
The faw requires that the death The law requires that the death ate has been signed by the etter age 2 should be detached for a	y P	Part II. Dther significant condition	ns contributing to	death but not res	sulting in the u	nderlying caus	e given in Par	rt I.	23e. Did tol	oacco use contrit	oute to th	ne cause of death?
Hecords, he law requires t a has been signe ige 2 should be o	Q P	Chronic Lymphoc	ytic Leu	kemia					1 🗆 Y	es 2⊠No 3	3 🗌 Prob	ably 4 Unknown
W rec	lete	0							24a. Wasa			psy findings available
he fa he has age 2	E C								autops	ned? de	ath?	mpletion of cause of
		25. Was case referred to medical					26. Pla	ice of Death	(Check only on	288	Yes	2   NO
OT VITA Physicien: this certific ral director,	o Be	examiner? 1 ☐ Yes 25⊠ No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA	Othor			ence 6 Other	r (Specif	y)
n OT ig Phy ter this neral d	n: T	27. Manner of Death	/A.4c	e of Injury onth, Day Year)	28b. Time o	f 28c.	Injury at Work?			w injury occurre		
ISION ( ttending I death. ctor: After y the funer	atio	1 Natural 5 Pending 2 Accident investig	ation	,,,	,,	М	1 Yes 2	□No				
DIVISION  I or Attending Fatter death.  I Director: After din by the fune	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Pla	ce of Injury - At h		reet, factory, of	fice	2	28f. Location (Si City or Town	reet and Number n, State)	r or Rura	l Route Number,
ital or	Cer											
DIVISION OF VITA  To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical E	g Physician: To the Examiner: On the	basis of examina								
hin 2 the the the the the the the the the the	Med	one) 29b. Signature and title of certifier		inner stated.		29c 1 i	cense numbe	nr .	<u> </u>	9d. Date signed	(Month.	Day Year)
5 <u>18</u> 5 <u>6</u>		200. Signature and the or certifier	1							•	•	
n		30. Name and address of person v	ato complete	Juse of dozeh (lea-	m 23a) /T		56024			May 8,	∠00	70
9							te 110	). Pri	nce Fre	derick	MD 3	20678
Sta	ite	31. Date filed (Month, Day Year)	1 2000 32.	Registrar's Sign	ature	1000	20 110	, 111.	TOU TIE	LOLICING		
Regist		Kenneth L. Abbo	1 ZUUD	Marian	Ship 1	GERALL)	r					

			For 1_ State	State of Ma	ryland	•	rtment of F				- ZHH	16443
			Registrar  1. Decedent's Name (First, Middle, Last)			Cer	unicate of	Dealii		Date of Deat	eg. No.	3. Time of Death
	Physici	an	Jessie Allen I						2.	Month	Day Year	5-01 M
	/Medic		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location	of Death	ray	4c. County of Dea	0
	Examin		Washington County			:	4 1	rstc			,	ngton
_			5. Social Security Number 6. Sec		(In yrs. las	st birthday)	If Under 1 Year			Date of Birth (Month, Day,		thplace (State or Foreign ountry)
	Funeral Director			344 000 5	15	Yrs.	Months Days	Hours	Min.	(Month, Day, arch 2	Year) Co	ountry) t Virginia
		l	Usual Residence of Decedent						1 12	11 011 2	,	
	rylan How		10a. State 10b. County		10c. City,	Town or Lo						10d. Inside City Limits
	e Ma	cto	Md. Washingt	on		H	lagerstov	m ————				1 ☐ Yes 2X No
	be filed within 72 hours after death with the Maryland at Hygiene. I of ther than "natural", or iteme 23a or 28a-f eltow event, the Medical Exeminer must be natified at	Funeral Director	10e. Street and Number 19616 Beaver Cre	ek Rd.			10f. Zip Code 21	740		1	0g. Citizen of What Co U.S.	
	eath	eral		12. Was Decedent E	ver in U.S.	. 13. v	Vas Decedent of H	lispanic Ori	igin? (Specify	Yes or No-	14. Race - Ame	erican Indian.
•	her d	F	1X Never Married 2 Married	Armed Forces? 1 ☐ Yes 24 No			Vas Decedent of H Yes, specify Cub			an, etc.)	Black, Whi	
ž	urs a	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2 No	Specify:			Specify:	White
9500-91212	2 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation		16a. Deced	lent's Usual Occup	ation	et of working		16b. Kind of Business	/Industry
7	within 72 ene. than "nei be Medic	ple	Elementary/Secondary (0-12)	College (1-4or 5+	+)		kind of work done	d)	n or norming		Constru	action
	filed wi Hygien other th	ပ္ပ	11				arpenter					
ם	d oth	Be	17. Father's Name (First, Middle, Last)  Elmer L. Mo	ore							Maiden Sumame)	
<u> </u>	2 should be and Mental ie marked o aumatic eve	၉									Dumlap	
Maryland	C1 (G) = (G)		19a. Informant's Name/Relationship (Ty	other)							City or Town, State, own, Md. 21	
	1 and Health em 27 ther tr		Jody D. Moore (Br	ouler,	20b. Pla	ce of Dispo	sition (Name of		Date		20c. Location - City or	
Baltimore,	Pages nent of int: if it		1 ☐ Burial 2X Cremation 3 ☐ F		cen	netery, cren	natory or other plaining Cremai		May 2 2006	4,	Smithsbur	
	교환경수 .		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens				. Name and Addre			12	525 Bradbu	
B	Departing any ir		1-0- /-	\	la 141 14		.L. Davi				ithsburg,	_
	_		23a. Part1. Enter the disease, or compl	ications that caused t	the death.	Do not ente	er the mode of dyin	ng, such as	cardiac or re			Approximate
	Physician		shock, or heart failure. List only or immediate Cause (Final			1000	lamban c	ิ ก.	7	110	h	Interval Between Onset and Death
3	/Medical		disease or condition resulting in death)	a. Anoxic  Due to (or as a	conseque	nce of):	vice op a	e Way	- V	02	,, ,	
	Examiner			Card	Le C	0	mess	- 0				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	conseque	ence of):						
	ocuted nd transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
760,	ate be executed hysicien and the burial-transit	Ä	resulting in death) Last	Due to (or as a	conseque	ence of):						
$\infty$	cate b	dlcal		d								
9 X	death certificat e attending phy id for use as th	Me	IF FEMALE:	23c. If yes, outcome o	of pregnant	m						
Вох	attend attend for us	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 ☐ Fetal d	death 3□	Ectopic pregnanc Other (specify)	у			23d. Date of de Month	Day Year
o.	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	une or dea	101 3	Curer (specify) _					
٦.	The law requires that the de: ate has been signed by the a bage 2 should be detached fo	by Physiclan/Med	Part II. Other significant conditions co	ntributing to death bu	t not result	ting in the ur	nderlying cause giv	en in Part I	ı.	23e. Did to	pacco use contribute to	o the cause of death?
Records,	uires sign		Mrost Conc	er (54	nsv.	nces	cell)			1 🗆 Y	es 2□No 3⊡15	robably 4 Unknown
<u></u>	w require been sign should b	Completed	Chronic OBSTAU	Tive Pi	(ma	NMY	Dispo	se		24a. Wasa	n 24b. Were a	utopsy findings available
æ	nysicien: The law nis certificate has t I director, page 2 s	E C	Herrensic		- ( )		171)(0	3 -		autops	prior to death?	completion of cause of
ta	en: T	BeC	25. Was case referred to sical		-/-			26 Place	e of Death (C		2 No 1 Yes	s 2□ No
<u> </u>	Physician: r this certifica ral director, p	To 8	examiner? 1 ☐ Yes 2 ☑ No	lospital:	nt 2 El	R/Outpatien	t 3 DOA Ct	200			ence 6 Other (Spe	acity)
<u></u>	g Ph er th		27. Manner of Death	28a. Date of Injury (Month, Day	y Z	28b. Time of Injury	28c. Inju				ow injury occurred	
<u>o</u>	Attending in death.  ector: After by the fune.	atlo	1 Matural 5 Pending 2 Accident investigation	(	/	,,		Yes 2□	No			
Division of Vital	I or Attending Phater death. Director: After th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Płace of Injur building, etc.	ry - At hom . (Specify)	ne, farm, str	eet, factory, office		28f.	Location (SI City or Town	reet and Number or R n, State)	ural Route Number,
	oltel o urs af ret D			1								
	Hospitel	Medical	29a. Certifier 1 Cartifying Phy (Check only 2 Madical Exami	ner: On the basis of and manner stat	examinatio	ledge, death on and/or inv	occurred at the tivestigation, in my o	me, date an opinion, dea	nd place, and ath occurred :	due to the ca at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the Hospitel or within 24 hours afte To the Funerel Director Completely filled in the Funerel Director Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the Funerel Completely filled in the F	Mec	29b. Signature and title of certifier	(Danie	(1)		29c. Licens	se number		2	9d. Date signed (Mon.	th, Day, Year)
	- > + 0		J. Firm Cox	)000000d	30		HOC	0611	7	1	1Ac 20	2006
•			30. Name and address of person who co	ompleted cause of de	eath (Item 2	23a) (Type.				11	7	D
			Francisco A	Doniels	DO	2	51 E.	Aut	retan	15)	Mores	TRUM, MD
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	ire Joseph	61				1	
	Regist	rar	MAY 2 4 2006	Little and	50 g	September 1	Para Para Para Para Para Para Para Para					

			State of Manyland / D	epartment of Health and M		
		•	1 _ State	Certificate of Death		a. No. 2006 16444
			Registrar  1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia		Mary Catherine Morrison		May 6,	2006 Year 11:00A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			701 Race Street Apt. 105	Cambridge	0.0	Dorchester
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birti	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Birthplace (State or Foreign Country)
	Director		166-12-3301 88 Usual Residence of Decedent		Sept 11	,1917 Pennsylvania
	yland		10a. State 10b. County 10c. City, Town			10d. Inside City Limits
7	e Mar	ctor	Maryland Dorchester	Cambridge		1X Yes 2 No
ζ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be multibut at angle.	Funeral Director	701 Race Street Apt. 105	10f. Zip Code 21613	10	g. Citizen of What Country? USA
ر د	eath ns 23	eral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
ر در	or Iten	핖	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 No Specify:	Hican, etc.)	Black, White, etc.  Specify: White
21215-0036	ours a	d by	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:			
5	72 h "natu	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)	ing 1	6b. Kind of Business/Industry
12	withir ene. than	duc	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Own Home
<u>დ</u>	illed Hygi other	e Cc	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M	aiden Sumame)
ılan	uld be Aenta rrked tric ev	To Be	William Muntz, Sr.	Julia		
Maryland	2 sholl and h		1	Mailing Address (Street and Number or Rura		
∑, <	and sealth m 27			1 Race St. Apt 105, Disposition (Name of		0c. Location - City or Town, State
altimore,	it of H it of H if ite or ot		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	y, crematory or other place)	/2006	Flagtown, New Jersey
Ħ	it. Pa intmer injury injury		' 4 □ Donation 5 □ Other (Specify) NeSCN  21. Signature MFuneral Service Prensee	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s		riagcowii, New Delsey
Ba	permi Depa Impo any ir	ş: ,	b ll b - s - some	22 Name and Address of Facility Thomas Funeral Hom 700 Locust Street	e, P.A. Cambrida	e. Marvland 21613
			23a. Part Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.			st, Approximate Interval Between
	Physician			dometrial Carcinon		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of	of):		
	Examine	_	Sequentially list conditions, if any, leading to immediate Due to (or a consequence of	metastases		
	ted nsit	Examiner	Cause (Disease or injury			
Ć,	te be executed ysician and e burial-transit	Exal	that initiated events resulting in death) Last C. Due to (or as a consequence of	of):		
760,	te be ysicia ne bur	cal	d			
89	death certificate be attending physical of for use as the be	Physician/Medi	IF FEMALE:			-
Вох	ath ce ttendi	lan/I	23b. Was decedent pregnant in the past 12 months?	3 ☐ Ectopic pregnancy		23d. Date of delivery  Month Day Year
0.	0 0 0	yslc	1 Yes 2 No 9 Unknown 4 Pregnant at time of death	5 Other (specify)		
<u>α</u>	requires that the deen signed by the hould be detached	y Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
of Vital Records,	quires n sign	ed by	Planetes Mellitus		1 🗌 Yes	S 2 No 3 Probably 4 Unknown
000	aw requir s been si 2 should l	Completed	Convertive Heart tailure		24a. Was an	
Ä	The law ate has b page 2 st	Com			perform	ed? death? ☑No 1 ☐ Yes 2♣DNo
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		h (Check only one	)
of \	Physician: this certific ral director,	2	1   Yes 2   No Hospital: 1   Inpatient 2   ER/Ou  27 Manner of Death 28a. Date of Injury 28b. 1		me 5 esider 28d. Describe hov	nce 6 Other (Specify)
	ling I. After fune	tion	1 ☑Natural 5 ☐ Pending (Month, Day Year) II	njury Work?  M 1 Yes 2 No	200. 00001100 1101	wingary occurred
Division	il or Attending after death. I Director: After d in by the fune	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	rm, street, factory, office	28f. Location (Str. City or Town,	eet and Number or Rural Route Number,
D	s after	Certification:	4 Homicide building, etc. (Specify)		Oily or rown,	State
	To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	edical (	29a. Certifier  (Check only  Medicel Examiner: On the basis of examination an	, death occurred at the time, date and place, d/or investigation, in my opinion, death occur	and due to the car red at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	To the h within 24 To the F	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29	d. Date signed iMonth, Day, Year)
	T wit		Gamen !!	451762		5/8/06
•			30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	,	1 4 4
			Eugene Nowmier DO 50	13 Bym St Car	mbridg	eM021613
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Accorde 1		
	Regist	rar	The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa			

		•	For State Registrar		artment of Health and Martificate of Death	lental Hygien Reg. N	2000	6445
	Dharaisis		Decedent's Name (First, Middle, Last)				ay Year 3. Tii	me of Death
	Physicia /Medic		LENA MARIE MOOF			MAY 07,	2006 203	35 ^M
	Examin		4a. Fecility Name (If not institution, give street		4b. City, Town, or Location of Death		ic. County of Death	
			WASHINGTON ADVENTIST  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	TAKOMA PARK  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	ONTGOMERY  9. Birthplace (S	tate or Foreign
	Funeral Director		227-42-0274	27 21 1	Months Days Hours Min.	(Month, Day, Yea	r) Country) 3,1932 Richmo	_
			Usual Residence of Decedent					
	how		10a. State 10b. County	10c. City, Town or Lo	cation			de City Limits Yes 2 ☐ No
:	Ba-1-	Directo	Maryland Prince Georg	es   Capitol He				1103 2 110
	vith th	Dire	10e. Street and Number	TTD.	10f. Zip Code 20743		Citizen of What Country?	
	filed within 72 hours after death with the Maryland Hygione. In the rhan "natural", or itema 23a or 28a-f ahow ant, the Macilcal Examinar must be notified at	erai	7003 FAWNCREST DRI		Was Decedent of Hispanic Origin? (Sp		14. Race - American India	an,
	Her de	Funerai	1 Never Married 2 Married 1	rmed Forces?	f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.	
2	urs al	by	_ v	Yes, Give ear or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: BLACK	
5	72 ho	Completed	15. Decedent's Education (Specify only highest grade com	poleted) (Give	dent's Usual Occupation kind of work done during most of work	ing 16b.	Kind of Business/Industry	
N	ner .	npie	Elementary/Secondary (0-12) C	oflege (1-4or 5+)	DO NOT use retired)		IVATE	
7	led w lygier her th		12 17. Father's Name (First, Middle, Last)	1 IICKE	r AGENT	e (First, Middle, Maide		
Maryland 21215-0056	ntal Hed of	Be	CHARLES ROBINS	SON	BLANCHE	MOYLER		
<u> </u>	thould the Me mark matic	၉	19a. Informant's Name/Relationship (Type, P		ng Address (Street and Number or Rui	al Route Number, City	or Town, State, Zip Code)	
<u>8</u>	ath and 2 s		Morris Moore, III /	Son 7906 H	Bardwell Court Cl	inton, Mar	yland 20735	
<u>6</u>	f Healthan		20a. Method of Disposition	20b. Place of Dispo	sition (Name of matory or other place)	Date 20c.	Location - City or Town, Sta	ite
Ê	Pege ient o nt: if ry or		1 ☐Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State	femorial Cem. 5/11	/2006 Lan	dover. Marvl	and
Baltimore,	permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Daparment of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment if firm 27 is marked other than "natural," or itema 23a or 28a-f show any injury or other traumatic avant, the Medical Examinar must be notified at once.		21. Signatule of Funeral Service Lonsee	0 0 2	Name and Address of Facility Alexander S. Pope 538 Marlboro Pike			
		-	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca				Appro	ximate al Between
	Physician		Immediate Cause (Final	Panal F	Failund			and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	09101	/	1	
	Examiner		Sequentially list conditions b	Chronic	KINNEN	dr 500	20	
	ם ב	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	7 40.			
	and end	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
8760,	cate be executed physicien and the burial-transit	a E						
687	icate phys s the	S S	d					
Box	daath centificate be executed e ettending physicien and nd for use as the burial-transit	Physician/Medical	IF FEMALE: 23c. If 23c. If	yes, outcome of pregnancy	76		23d. Date of delivery	
ň	daath e ette d for	icia	in the past 12 months?	Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month Day	Year
P. O.	t the by the tache	hys	9 ☐ Unknown	Unknown				
	The law requires that the daath certific Ne hes been signed by the ettending p oage 2 should be detached for use as	by P	Part II. Other significant conditions contribu	ting to death but not resulting in the u	nderlying cause given in Part I.	N .	o use contribute to the caus	~/
2 G	w requir been si should I	ted				1 Tes	2 No 3 Probably	4 Inknown
Division of Vital Records,	e law r hes be je 2 sh	Completed				24a. Was an autopsy	24b. Were autopsy find prior to completion	dings available n of cause of
<u> </u>		5				performed 1 ☐ Yes 2 ☐		0
Vita Vita	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	tal: _/	26. Place of Dea			
o	Phys this ral dir	.T	27 Manger of Death 28	1 Lymp unit 2 EH/Outpatie	1 3 DOA 4 I Nuising H	ome 5 Residence 28d. Describe how in	6 Other (Specify)	
0	ttending Phy death. stor: After this / the funeral c	tlon	1 Natural 5 Pending 2 Accident investigation	Ba. Date of Injury 28b. Time of (Month, Day Year) Injury	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No		,,	
/ISI	or Attending after death. Director: Afte in by the fune	fica	3 Suicide 6 Could not be	Be. Place of Injury - At home, farm, st	reet, factory, office	28f. Location (Street	and Number or Rural Route	Number,
á	al or A s after il Dire	Certification:	4 Homicide	building, etc. (Specify)		City or Town, Sta	16)	
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical	(Check only 2 Medical Examiner:	On the basis of examination and/or in	h occurred at the time, date and clane vestigation, in my opinion, death occur			use(s)
	thin 24 thin 24 the F	Med	29b. Signature and title of certifier	and manner stated.	29c. License number	29d. (	Date signed (Month, Day, Yo	ear)
1	To T Con		290. Signature and times forming.	112/10	DUID	121	cioln	
,	12		30. Name and address of ners it who is make	oted gause of death (Item 23a) (Type)	Print)	711	- 10/01	>
1	-(3)		Yehrys	NegusSI	eim D W	oshing.	ton Ad	V. Mrs
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 1 1 2006	2. Pégistyar's Signature	lo .	,		*1

Anthony D. McPhatter

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

inthony D. Mich	1		e of Death	Reg. N	0. 2006 164
Physicia		1. Decedent's Name (First, Middle,Last)		Date of Death     Month Da	y Year 3. Time of Death
Medical Exami		Anthony Delanta McPhatter		May 5, 2006	2354 1115
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	٦	4c. County of Death  Baltimore County
		6139 Twilight Court	White Marsh	lo pair (Distance	M/DD/YYYY) 9. Birthplace (State or
Funeral	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24Hrs Months Days Hours Mir	<b>⊣</b>	Foreign
Director		216-88-5031   1XM 2 F 31	Yrs.	01/08/19	O75 Country) MD
	Ī	Usual Residence of Decedent  10a State 10b County 10c City, Town or I	conting		10d. Inside City Limit
w any					1 X Yes 2 N
laryland 8a-f show at once.	ö	MD Baltimore Baltimor			
Mary 28a- d at	rect	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?
the 3a or otifie	٥	6139 Twilight Court	21206		JSA
ms 2.	Funeral Director	11. Marital Status 1 X Never Married 2 Married Armed Forces? 12. Was Decedent Ever in U.S Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto</li> </ol>		<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
deatl or ite must	틸	1 Yes 2X No			0 - 7 - 71 - 1
after	ā	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify: cedent's Usual Occupation (Give kind of	work dono 160	Specify: Black b. Kind of Business/Industry
hours natu		dur	ing most of working life. DO NOT use re		b, Killid of Busiliess/Illidustry
36 n 72 ical	Completed	, , , ,	n1	١,	Private
withi withi	ē	17 Father's Name (First, Middle, Last)	Dealer 18.Mother's Nam	e (First, Middle, Maid	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Nedica	Be C		Vyonne	McPhatter	
212 ould be Menta mark ic even	To B	William Murray  19a Informant's Name/Relationship (Type, Print )  19b. N	Mailing Address (Street and Number or		, City or Town, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Yvonne Jones/Mother 201	I St. S.W. #437 W	ashington	, DC 20024
and and lealth tem		20a. Method of Disposition 20b. Place of D	isposition (Name of cemetery,		Dc. Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hes Important: If ite		1 ABurial 2 Cremation 3 Removal from State	or other place)	/12/2006 1	Landover, MD
timent trant		4 Donation 5 Other Specify: Harmony 21. Separature of Funeral Service Licensee	Memorial Park   05 22. Name and Address of Facility Ma		
Bal Permi Depai Impo			4308 Suitland Rd.,		
Physician		23a. Pa/ll. Enter the disease, or complications that caused the death. Do not e	nter the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart Approximate Interv
- /Medical	a 115	failure. List only one cause on each line.			Between Onset an Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Gunsnot vound of Neck  Due to (or as a consequence of):			
		h			
	Je.	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Unisease or injury that initiated events resulting in death.) Last Due to (or as a consequence of):			
ed ed	EX	Cyclic resulting in death, East.			
760, Totate be executed sphysician and the burial - transit		d. UNPENDED AMENDED			
760, icate be e g physicia the buria	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d Date of delivery
: <b>68760</b> , certificate be anding physicilise as the buri	_	23b. Was decedent pregnant in the	Fetal death 3 Ectopic pregr	nancy	Month Day Year
x 6 h cert tendii	sician	4 Pregnant at time of death 5	Other (Specify)		
Box 68 c death certif the attending ed for use as	Phys	1 Yes 2 No 9 Unknown g Unknown			
Records, P.O. Box 68.  The law requires that the death certificate has been signed by the attending page 2 should be detached for use as 1	by P	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.		cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown
signe signed the d					
rds requ	ee			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
eco ne law te has	Completed			performe	
Division of Vital Records, pital or Attending Physician: The law requirement after death reral Director: After this certificate has been so filled in by the funeral director, page 2 should be	0		26.Place of Death (Chec	k only one)	
Vita hysicia this cer	B B		patient 3 DOA Other Nurs	sing Home 5 Res	sidence 6 🗸 Other: Scene
ing Phy After th	F.		ne of Injury 28c. Injury at Work?	28d. Describe how	injury occurred
nding sth	ë	1 Natural 5 Pending May 5, 2006 2343 h	nrs 1 Yes 2 ✓ No	Subject shot	
ivision or Atteno after death Director:	ig.	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farr	n, street, factory, office building, etc.		et and Number or Rural Route Number, C
Divisior  Bospital or Attenc A hours after death Funeral Directors etely filled in by the	Certification:	Suicide 6 Could not be determined (Specify) Single Family Ho	me	or Town, State 6139 Twilight (	Court, White Marsh, Md.
Hos Fun ely	. 1	29a Certifier	occurred at the time, date and place, a	nd due to the cause(s	) and manner as started
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director,	Medical	one) 2 Medical Examiner: On the basis of examination and/or inv	estigation, in my opinion, death occurred	d at the time, date and	d place, and due to the cause(s)
T. w. C.	§	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month, Day, Year)
		1/ )/ als lesses	O.C.M.E.	, r	May 7, 2006
		name and address of person who completed cause of death (Item 23a)			
0 (10)	1		Penn Street, Baltimore, MD 21	201	
	 State	31. Date filed (Month, Day, Year) . Registrar's Signature	2 .0		
Regi					
DHMH 17 Rev 1	/2001		GINAL		

			For 1 - State Registrar	State of M	aryland / Dep <i>Ce</i>	artment rtificate	of He	ealth a Death	nd Me	ental Hy	giene	006	1644
			Decedent's Name (First, Middle, I	ast)						2. Date of De	aath		3. Time of Death
	Physici		EMMA PAULINE MO	ገጽልጥ						Month May 6	Day 2006	Year	3:55 a M
	/Medic Examir		4e. Fecility Name (If not institution, g			4b. City, To	own, or L	ocation of	Death	They to	,	inty of Death	
			Crofton Conval	escent Cent	er	Crof	ton				Anne	e Arun	del
4.,	Funeral				e (In yrs. last birthday	If Under 1		If Under 2 Hours	4 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)	9. Birth	plece (State or Foreign
	Director		215-82-0202	IL M ZUAF	101 Yrs.					Sept.	1, 1904		ington, DC
	and *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or L	ocation							10d. Inside City Limits
	Aaryli sho	ŏ	Manual and David and	0 1 -	D .								1 ☐ Yes 2X No
	28a-	rect	Maryland   Prince	George's	Bowie	10f. Zip C	ode				10g. Citizen	of What Cou	intry?
	with Se or	Funeral Director	1/007 11 -1-1 0	D.							U.S.A.		,
	Jeath June 23	era	14997 Health Ce	12. Was Decedent	Ever in U.S. 13.	Was Deceder	nt of His	panic Orig	in? (Spec	ofy Yes or N	o- 14. l	Race - Ameri	
က	or Iter	Fur	1 Never Married 2 Married	Armed Forces?		If Yes, specify			Puerto F	lican, etc.)		Black, White,	, etc.
8	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show liteal Examerer must be confilled at	i by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>]</b>	M MO	Specify:			Spe	whi	ite
21215-0036	72 h netu	Completed	15. Decedent's (Specify only highest of	Education grade completed)	(Give	dent's Usual	done du	ion ring most	of workin	g	16b. Kind o	f Business/In	ndustry
21	within ene. than "	id II	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use	retired)						
	filed withi Hygiene. other than	CO	12	ael .	Home	maker	- 7.	I Mathar	r'e Nama	/Eiret Middle	Own I		
ano	ould be fi Mental H larked of	Be	t7. Father's Name (First, Middle, La	51)								name)	
Ž	should nd Men marke umaric	To	James Brady  19a, Informant's Name/Relationship	(Type Print)	19h Mail	ing Address (				Recto:	r per, City or To	wn State Zi	n Code)
Maryland	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		Mildred M. Plass								le, Mar		·
	Health Health tem 27 other tr		20a. Method of Disposition	Daugh	20b. Place of Disp	osition (Name	of			ate		on - City or T	
10	Pages nent of nt: It i		1 ☑ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe		Fort Lin			- 1	5/10/	2006	Brant	book	Maryland
Baltimore,	그 본 본 등		21. Signature of Fuperal Service Vic								uneral		
Ä	Department Department on the once		Hallett 1	las							tsville	-	
	Physician /Medical Examiner	Examiner	23a. Fart. Enter the disease, or or shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflitated events	a. Cardia.  Due to (or as	c Arrythmi: c a consequence of): a consequence of):		or dying.	Such as C	ardiac of	Tespiratory 2	111651,		Approximate Interval Between Onset and Death
.O. Box 68760,	ne death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	d	2 Fetal death 3	⊒Ectopic preg						Date of deliv Month	ery Day Year
<u>α</u>	ss that the	by	Part II. Other significant condition	contributing to death t	out not resulting in the	underlying cau	ise given	in Part I.					he cause of death?
ord	w require	ted	Dementia								Yes 2□No	3 PIO	bably 4 X Unknown
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of	ding Physician: n. After this certifications funeral director,	2	1 ☐ Yes 2 📉 No	Hospital: 1 Inpati				4M Mul			idence 6 🗆		<b>(y</b> )
no		ion	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time ( Injury	M 200	Work?	at es 2 ⊡N		sa. Describe	how injury oc	currea	
Division	or Attendifier death	Certification:	2 Accident Investigal 3 Suicide 6 Could no 4 Homicide determini	be 28e. Place of In	jury - At home, farm, si tc. (Specify)						(Street and Nu wn, State)	ımber or Run	al Route Number,
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	To the within 2 To the complet	Med	29b. Signature and title of certifier	and marmer st	arou.	29c. I	License	number			29d. Date sig	ned (Month,	Day, Year)
	H 3 F 8					D5	7028	3			Matr Q	, 2006	
0	(M)	)	30. Name and address of person wi	no completed cause of	death (Item 23a) (Type						nay o	, 2000	,
1-	-0		Aditya Chopra,		idgely Ave		231.	Anna	moli	s. Mar	vland	21401-	1092
		ate	31. Date liled (Month, Day, Year)	. Regist	rar's Signature		J. ~ 3				Januari V	TV.L	+3/1/-
	Regist	rar	MAY 1 0 20	UD Brance	K lin	451							

State of Maryland / Department of Health and Mental Hygiene () 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day **Physician** 2006 15, 7:25 p.m. May Mason George Arthur /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Lexington Park St. Mary's 46217 Scott Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1X M 2□ F Yrs 79 1927 Maryland March 7, Director 216-28-8032 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 28e-1 ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Lexington Park St. Mary's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 'natural', or items 23a or United States 20653 46217 Scott Court death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Itam 27 is marked other then "natural", or iten eny injury or other traumatic event, the Medical Examinar once. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married **Black** Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor School & Church 9 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Edward Mason Georgia Elizabeth Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 46217 Scott Court, Lexington Park, Maryland 20653 Mildred Mason / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Cemetery 5-19-2006 Bushwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityBrinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** aure disease or condition resulting in death) Mes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any carry immunate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-translt Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. ettending physicien Physician/Medical the IF FEMALE: 980 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 Unknown cate has been sig. . page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 2 XNo 1 Tyes certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one) Be examiner' Other: 4 \( \sum \) Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 X Residence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Magner of Death Certification: After 1 Natural 2 Accident 1 Yes 2 No investigation Director: , 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a

To the Funeral I

completely filled To the Hospitei 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H005575 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Schmidt, D.O., 23415 Three Notch Road, California, Maryland 20619 31. Date filed (Month, Day, Year) MAY 18 2006 Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene?

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	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of De Month		Yeer	3. Time of Death
	/Medic	al	George	Marsh		4 0: :	P		05	08	06	2137 M
	Examin	er	4a. Fecility Name (If not institution, give s PENINSULA NEGIONAL	reet and number) Medicol Lok	611	4b. City,	Town, or Locati	/			inty of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under	1 Year   If War	der 24 Hrs.	8. Date of Birt	th		place (State or Foreign intry)
ь	Director		1-1-20-3497	M 2□F 69	Yrs.	Months	Days Hou	rs Min.	6/4/1	336"		nsylvania
	and		Usuel Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation					Т	10d. Inside City Limits
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39	be filed within 72 hours after deeth with the Maryland ital Hygiene. I hour so other then "naturel", or items 23a or 28e-f ehow event, the Medical Examinat must be notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 □ No If Yes, Give Army Year or Dates:		1 ☐ Yes 2	No Spec	city:		Spe	ecity: W	hite
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	To the Hospital or Attending Physicien: The law within 24 hours effer death.  To the Funerel Director: Affer this certificate hes completely filled in by the funeral director, page 2 a	Medicai	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, deatl ation and/or in	h occurred a vestigation,	at the time, date in my opinion,	and place, death occurr	and due to the red at the time,	cause(s) and date and plac	manner as s e, and due to	stated. o the cause(s)
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	D. 26		30. Name and address of person who could be control of Succession who could be control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the co	0	m 23a) (Type,	Print)		0. /	in Ma	021	2.	
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DHMH 17 Rev 1/2001

903-29-2875

George March

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MAY 14, 2006 5:34 PM CHERI ANN MC MAHON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Sociat Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕽 F 47 Yrs. 283-64-7957 Director APRIL 23,1959 WASH. Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. tnside City Limits 10a. State 10b. County : if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No CHARLES BRANDYWINE MARYLAND Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 16341 WOODVILLE ROAD 20613 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Ite 1 Never Married Married Baltimore, Maryland 21215-0036 1 Yes 2XXIVO Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) U.S. GOVERNMENT DEPT. OF INTERIOR 12 ADMINISTRATIVE ASSISTANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROBERT PERRY ST. ARNOLD SHIRLEY ANN ADAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JAY B. MC MAHON-HUSBAND 16341 WOODVILLE ROAD, BRANDYWINE, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, Slate 1XXurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 5-19-06 OAKLAND CEMETERY WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) M00479 22. Name and Address of Facility 21. Signature of Fuperal Service Licensee Un RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final MYOCARDIAL INFARCTION **Physician** ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Squadially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. tf yes, outcome of pregnancy
1☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown s been signed b Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY ARTERY DISEASE 4 Unknown 1 Yes 2 No 3 Probably DIABETES 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificate has b irector, page 2 s 1 Yes 2 No Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 Yes 2 No ŧ Certification: To 1 Inpatient After th 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 TYes 2 No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JODAIC D40324 MAY 15, 2006 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) 7503 SURRATTS ROAD, CLINTON, MAKYLAND 20735 JODRIE, M.D. TERRY 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		1	For State of M	aryland / Dep <i>Ce</i>	ertificate of I		ntal Hygiene Reg. No	AUUD.	645
			Decedent's Name (First, Middle, Last)	01)0	1.1		Date of Death	v Year	3. Time of Death
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	/Medic Examin		a. Facility Name (If not institution, give street and number	)	4b. City, Town, or	Location of Death	40	. County of Deeth	
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	Funeral		1 🕅 M 2 🗆 F	ge (In yrs. last birthday	Months Days	Hours Min.	Dale of Birth (Month, Day, Year,	) Cou	
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	land ow		10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
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Ba	permit. Departr Importe any inje	ž 1	Loli et to Illa		4739 Balt	imore Ave.	, Hyattsv	ille, MD	20781
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Division of Vital Records,	i or Attending Physician: after death. Director: After this certific I in by the funeral director.	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, stre fy)	et, factory, of	ffice		ation (Streety or Town, S	et and Number or Ru State)	ıral Route Number,
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 8:00 A M 29 2006 April Ruth M. Peters /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Riverdale Crescent Cities Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours 1 ☐ M 2 🗓 F Months Days Dec. 4, 1918 Virginia Director 579-32-3176 Usual Residence of Decedent 10c. City. Town or Location 10d, Inside City Limits the Maryland 10b. County 10a. State 28a-f show the Mudical Exactner must be notified at 1 XYes 2 No Riverdale Maryland Prince George's Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö United States 20737 238 4409 East West Highway death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 o 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 □ Divorced þ natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) than Elementary/Secondary (0-12) I Hygiene. Private permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other it any injury or other traumatic event, IIIs ODGs. Domestic Work Unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Cabell Wash Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 723 Rittenhouse St., Hyattsville, MD 20783 Lowell M. Gaines/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5/5/2006 Brentwood, MD Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee 20019 4001 Benning Rd., NE Wash., DC NOINTON 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Diabetes Mellitus **Physician** /Medical Due to (or as a consequence of) Examiner Peripheral Artery Disease Sequentially list conditions. Sequentiary list conditions, r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) Box 68760, attending physicien Completed by Physician/Medical esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year ned by the atter detached for u 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. g a 1 Yes 2 No 3 Probably 4 Unknown Advanced dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Work? Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide after To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 4, 2006 D25079 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20706 7404 Executive Pl., #502, Lanham, MD Don H. Yablonowitz, M.D. 32. Registrar's Signature 31. Date fifed (Month, Day, Year) State 1 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day 6 **Physician** 2006 10:00 AM May Ethel Bell Pullen /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2√2F Yrs. . Virginia 71 577-48-5819 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 28a-f show the Medical Examiner must be notified at 1 → Yes 2 □ No Bowie Directo Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23e or 20720 12615 Willow Marsh Lane United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. African filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ American 3 ☐ Widowed 4 X Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Clerical Government permit. Pages 1 end 2 should be filed v Department of Health and Mental Hygiel Important: If Item 27 is marked other th eny injury or other treumatic event, that once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Conway Joseph Tolliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12615 Willow Marsh Lane, Bowie, MD Loretta A. Graham/Daughter Baltimore, 20b. Place of Disposition (Name of park cemetery, crematory or other place) rk 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Maryland National Mem. 5/10/2006 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee 4001 Benning Rd., NE Wash., DC 20019 Menon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Cerebrovascular Accident /Medical Due to (or as a consequence of): Examiner Brain Vessel Swelling Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed led by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been sign page 2 should be 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 ANo 1 ☐ Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this co Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies when Wilson MI 10061937 6 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Candance L. Wilson, M.D. 1500 Forest Glen Rd., Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MINNIE ESTHER PARKS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner tov 45 OSpita If Under 24 Hrs. 8. Date of Birth If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 F Days Hours JUN 20 1928 MARYLAND 77 Yrs Director 213-22-8287 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State works ! or than "natural", or items 23a or 28a-f shoving Medical Examinar must be notified at 1XYes 2 No Director MD TALBOT TRAPPE 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 29160 KRISMORE CT. 21673 death v Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 Ano If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE ģ 3 XWidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. OWN HOME 0 HOMEMAKER 12 Item 27 is marked other other traumatic event, II 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental MAY HELSBY NELSON CLIFFORD BLANN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 308 FALL LANE, EASTON, MD 21601 KEITH A. PARKS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Himportant: If Ite any injury or of pnce. 1 ☐ Burial 2 **X**Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 5/8/2006 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Loud MERCEROR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of) Failur Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury e to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit rdvm ce that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed cate 20 No 2 No 1 Yes 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) certifi examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours after To the Funaral Dire pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Haider MO sarrat 31. Date filed (Month, Day, Year) 32. Regis ar's Signature State MAY 0 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 13, 2006 7:45 a.m. Henry Edward Pettaway Mav /Medical 4c. County of Death 4a. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown 8. Date of Birth (Month, Day, Year)
Oct. 30, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1**X**□M 2□F Yrs. 1941 Director 366-40-4216 64 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ir then "neturel", or Items 23a or 28a-f show tre Medical Examinational be notified at 1 ☐ Yes 2 X No Maryland St. Mary's California Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20619 45303 Elmbrook Drive United States death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours atter ariment of Health and Mental Hygiene.
ortant: If item 27 is marked other then "neturel", or ite injury or other traumatic event, it a Medical Examina. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black ρ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Commissioned Officer U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Mills Anna Pettaway Davenport 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Pettaway / Wife 45303 Elmbrook Drive, California, Maryland 20619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre. 5-16-2006 Charlotte Hall, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M01206 22955 Hollywood Road, Leonardtown, MD 20650-0279 Kyle S. Simons Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ESRD **Physician** /Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine bowels attending physicien end for use es the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed schemic Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Cancel Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) by the a 9 Unknown 9 Unknown should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cete has b autopsy performed 1 Yes 2 No certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death Check only one examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 X No this Atter thi 28a. Date of Injury (Month, Day Year) 28c, Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural
2 Accident 5 Pending death. investigation Director: 3 T Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47066 5.15.06 sual 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22650 Cedar Lane Court, Leonardtown, Maryland 20650 Avani D. Shah, M.D., 2006 Registar's Signature

DHMH 17 Rev 1/2001

State

Registrar

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		Maplewood Par 5. Social Security Number	6. Sex			iome		nesda 1 Year	a. If Under	24 Hrs.	8. Date of B	Birth				e or Foreign
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or items 23e or 28e-f ehow ency injury or other traumatic event, the Medical Examinar must be notified at once.		10a. State 10b. County				ty, Town or L									10d. Inside	City Limits es 2 ☐ No
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U	-	30. Name and address of person	who co	mpleted cause	death (Iter	m 23a) (Type	Print)									
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	Physici	an	1. Decedent's Name (First, Middle, Las	(t)				2. Date of De. Month	Day Year	3. Time of Death
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Vital Records,	uires signe ld be	d by						1 🗆	Yes 2,75\$No 3⊟1	Probably 4 DUnknown
Ö	s been	olete						24a. Was	an 24b. Were	autopsy findings available
Ä	The law cate has page 2:	Completed						auto perfo 1 ☐ Yes	rmed? death'	completion of cause of
Ita	icien: Th certificate rector. pag	Be C	25. Was case referred to medical examiner?					eath Check only	one)	
	hys this al di	၉	1 Yes 2 No	Hospital: 1 Inpatient 2 I	ER/Outpatier	IL 3 DOA			dence 6 Other (Sp	ecify)
u O	ding I h. After funer	tlon	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wo	rk? ]Yes 2∐No	200. Describe	now injury occurred	
Division of	after death.  I Director: After this certific din by the funeral director.	fica	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At he	ome, farm, sti	reet, factory, office			Street and Number or	Rural Route Number,
á	tel or s afte el Dire ed in b	Certification;	4 _ nomicide	building, etc. (Specif	y/ 			City or To	wii, State)	
	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by:	Medical		nysician: To the best of my kno miner: On the basis of examina						
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date signed (Mo	nth, Day, Year)
	CO		)er/	rooli E	) 0	· Ho	0544	24	5-14-	06
	Jy Jy		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,	Print)	2-1 11:0	200	5-14-	1093
	1		31. Date filed (Month, Day, Year)	d. 20 E.  32. Registrar's Signa	limo.	nium	CAI CITY		778613	
	Sta Regist			2006 Marie	ature	book				

		•	1 - For State Ragistrar	State of	Marylan		rtmen tificate			and M	lental Hy	giene Reg. Nó	006	16	459
	Physicia	20	1. Decedent's Name (First, Middle, La	st)							Date of De Month	Day	Year		e of Death
	/Medic		William K. Rams								May		2006	23	36 p⁴
	Examin	er	4a. Facility Name (If not institution, give Southern Maryland				4b. City,		Location of	of Death			nce Geo		S
	Francis		5. Social Security Number 6. S		. Age (In yrs.	last birthday)	II Under	1 Year	if Under		8. Date of Bir				te or Foreign
	Funeral Director			<b>™</b> 2□ F	59_	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 12/2/1	946	West	olace (Sta ntry) Va	
3	2 2		Usual Residence of Decedent  10a. Slate 10b. County		10c. Cit	y. Town or Lo	cation							10d. Inside	e City Limits
	shov	5	DC			ingtor									res 2 □ No
1	28e-1	rect	10e. Street and Number		wasi	11116001	10f. Zip	Code				10g. Citizer	n of What Cou	ntry?	
	38 of	Funeral Director	182 36th Street	NE #1	`.			2001	۱9			U	SA		
1	ama 2	ner	11. Marital Status	12. Was Deced	dent Ever in U.	.S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	- 14.	Race - Amen Black, White		١,
9	or It	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【Xi Divorced	1 ☐ Yes :	2 💢 No		1 🗆 Yes		Specify:		,		pecify: Bla		
0000	illed within 72 hours after death with the Maryland Hygiene, then "hat ure!", or Itema 23a or 28e-f show bit, the Medical Examiner must be notified at		15. Decedent's E	Year or Da	tes:	16a. Dece	ient's Usua	d Occupa	ation				of Business/Ir		
2	n na	piet	(Specify only highest gra	ade completed)  College (1-	40r 5+)	(Give	kind of wo	rk done a	during mos	t of worki	ng			ŕ	
21212	giene gritha r tha	Completed	Elementary/Secondary (0-12)	College (1-	401 34)	Truck	Dr	iver				Gov	ernmen	t	
yland	id be file ental Hy ked oth	To Be (	17. Father's Name (First, Middle, Last Robert Paige	)						r's Name trud	e (First, Middle e Rams		ımame)		
Mary	permit. Pages 1 and 2 should be lifed within 72 hours after death with the Mayrian Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  By Injury or other traumatic event, the Madical Examinar must be notified at once.	_	19a. Informant's Name/Relationship (	<i>Type, Print)</i> sey - Br	other	19b. Mailir					n Route Numb			o Code)	
ည် .	s 1 an f Heal itam 3 other		20a. Method of Disposition		20b. F	Place of Dispo emetery, crer	sition (Nar	ne of			Date		tion - City or T	own, Slate	Э
Ë,	Page nent o int: #		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia		tate	tropol:					/2006	Alexa	ndria	VA	
baltimore,	permit. Departn Imports any Inju		21 Signature of Funeral Service Lice	nsee O	Ź						pe Fune Washir			20	
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that ca	used the deat ich line.	h. Do not ent	er the mod	e of dying	g, such as	cardiac (	or respiratory a	rrest,		Approxi Interval	mate Between and Death
	hysician		Immediate Cause (Finat disease or condition resulting in death)	a	CAR	MC	Aa	ny	the	6	*			Onsora	
	/Medical Examiner		resulting in doutin)	Due to (d	or as a conseq	uence of):		,	8-1		n 12				
8		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (d	or as a conseq	uence of):	ny	7	alle	4	1)(}	601	2		
	outed id ansit	Examiner	that initiated events	C											
Ď,	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (d	or as a conseq	uence of):									
-	98	dical	•	d											
χ ×	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE:	23c. If yes, outo	come ol pregna	ancv						230	d. Date of deliv	'en/	
ž g	atten atten I for u	cian	23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq Yes \) 2 \( \subseteq No \)	1 Live bi	rth 2 ☐ Feta ant at time old	il death 3	Ectopic production of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of					200	Month	Day	Year
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Vital Records, P	w requires that the been signed by the should be detache	کِ	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the u	nderlying o	ause give	en in Part I	•			contribute to		_
Ö		Completed									24a. Was		24b. Were aut	opsy lindir	ngs available
Y Y	sicien: The law certificate has b irector, page 2 sl	mo									auto perfo	ormed?	death?	2 No	of cause of
<u> </u>	sien: artifica ctor, p	Bec	25. Was case referred to medical examiner?							of Deatl	n (Check only	one)			
<u> </u>	al d	မ	1 ☐ Yes 2 No	1, ,		ER/Outpatier			4   140		me 5 ☐ Resi			fy)	
	ing Affer une	tion	27. Manner of Death  1 Natural 5 Pending investigation		l Injury h, Day Year)	28b. Time o Injury	м	8c. Injury Work	γαι ∢? Yes 2∐		28d. Describe	now injury o	occurred		
Division	Atten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not b		of Injury - At h	ome, farm, sti	eet, factor				28f. Location (		Vumber or Rur	al Route f	Vumber,
2	tal or A s after at Director	Certification:	4 Homicide	buildir	ig, etc. (Specif	'y) 					City or To	wn, State)			
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the miner: On the ba and mann	isis of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my or	ne, date an pinion, dea	nd place, ith occurr	and due to the ed at the time,	cause(s) ar date and pl	nd manner as a ace, and due	stated. to the cau	se(s)
	To th To th comp	Me	29b. Signature and title of certifier	16	)				number				signed (Month,		ir)
^	(2)		• <		0			0041	.580			May 5	5, 2006		
1	(4)		30. Name and address of person who Dr. Scott Kelso		e of death (Iter urratt:		Print)	on M	d 207	35					
	Sta	ate	31. Date filed (Month, Day, Year)	<b>₽</b> 2. Re	egistrar's Signa	atur <u>e</u>									
Sec.	Regist		MAY 1 1 200	6	w K	Sie	10								

Ramsey

Certificate of Death

4b. City. Town, or Location of Death

Prince Frederick

3. Time of Death

8:15 a

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 🗙 No

State of Maryland / Department of Health and Mental Hygiene

Maryland

14. Race - American Indian, Black, White etc.

23d, Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

white

2. Date of Death

8

Month

May

Day

2006

4c. County of Death

Calvert.

1. Decedent's Name (First, Middle, Last) Physician /Medical 4a. Facility Name (If not institution, give street and number) Examiner

1 - For State Registrar

Mae

Tndia

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Oay, Year) 026358 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDFRICK 73 WEIGE 32. Registres Signature 31. Date filed (Month, Day, Year) 2006

State

Registrar

16461

Please	Type or Print in Black Indelible Ink. En	isure All	Copies A	re Legi	ible
For	State of Maryland / Department of Health	th and Me	ental Hygie	ne) n	
1 - For State Registrar	Certificate of Dea		Reg.	10	Ų I
1. Decedent's Name (First, Middle, La	st)		2. Date of Death	Day	Von

Physicia /Medic Examin

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show enpirity or other traumatic event, the Madical Examinar must be notified at engage.

Baltimore, Maryland 21215-0036 MAY 6, 2006 7:00 a.m.

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

EDWARD REYNOLDS

n	<ol> <li>Decedent's Name</li> </ol>		,,						2.	Date of Deat		V	3. Time of Death
			Edwa	rd Lero	y Reyno	olds				Month Ma	ay 6, 20	06 Year	7:00 A
r	4a. Fecility Name (/		, give street and n Stella Maris	u <i>mber)</i>		4b. City,	, Town, or L	ocation of 0			4c. Co	unty of Death Balt	imore
	5. Social Security N 213-56-4		6. Sex 1 ( <b>X</b> M 2 □ F		yrs. last birthda 54 Yrs.	y) If Under Months	Days	If Under 24 Hours	Hrs. 8. Min.	Date of Birth (Month, Day, May 10	Year) ), 1951	9. Birth Cou	place (State or Fore Maryland
	Usual Residence of			100	. City, Town or	Logation							10d. Inside City Limi
	10a. State MD	10b. County	Calvert	100	. City, Town or	Location		St. Leor	ard				1 Tyes 2
	10e. Street and Nut 5830 Macka					10f. Zip	p Code	20685	5	1	0g. Citizen	of What Cou U.S.	
	11. Marital Status  1 Never Marr 3 Widowed		Armed F	2 <b>∑</b> No 3ive	in U.S. 13	If Yes, spe	ecify Cuban	panic Origir , Mexican, F Specify:	n? (Specif Puerto Ric	y Yes or No- an, etc.)		Race - Amer Black, White ecify: Bla	, etc.
	(Spec		st grade completed	d) (1-4or 5+)	(Gir	cedent's Usu ve kind of wo . DO NOT u	ork done du use retired)	ring most o	f working		16b. Kind	of Business/li Pain	
		0					Ра	nter					9
	17. Father's Name	(First, Middle,	Last) Edward Frai	nklin Rey	nolds			18. Mother's	Name (F	irst, Middle, i Mat	Maiden Sui Ne Lee	,	
	19a. Informant's N Charles R									MD 2068		own, State, Zi	p Code)
	20a. Method of Dis 1 Burial 2 4 Donation	Cremation	3 □Removal from		-	position (Nai rematory or coolitan Cre	other place	)	Date 05/12		20c. Locat	ion · City or T Alexand	own, State dria, VA
	21. Signature of Fu	den C	Licensee	elO		22. Name ar 14				d Prince I	- rederio	k, MD 20	0678
	Sequentially list or if any, leading to if cause. Enter Und Cause (Disease of that initiated event resulting in death)	niniediate erlying r injury s	c		nsequence of):								
BOID MINING	rif any, leading to if cause. Enter Under Cause (Disease or that initiated event	antipregnant of months?	c	o (or as a cor	egnancy	3 ⊟Ectopic p 5 ⊟ Other (s;					23d	. Date of delin	very Day Year
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Were aut prior to codeath? 1 Yes  Courred  Courred  Courred  Courred  Courred  Courred  Courred  Courred  Courred  Courred  Courred	the cause of death?  the cause of death?  bably 4 Valunkno  opsy findings availa  ompletion of cause  2 No  fry) HOSPICI  ral Route Number,  stated.  to the cause(s)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 8:10 AM 06 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CHESTERTOWN KENT CHESTER RIVER MAANOR If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F Yrs. Director 88 Mar.14,1918 <u>Maryland</u> 170-20-6451 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ?7 is marked othar than "natural", or itame 23s or 28s-f abov traumatic avent, the Modical Exercit at must be mutified at 1 TYes 2 No Director Maryland Queen Annes Church Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number deeth with 21623 USA 120 Willson Lane Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages t and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itam any Injury or other traumatic avent, the Mental or other traumatic avent, the Mental or other traumatic avent, the Mental or other traumatic avent. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specity: Specify. 3 X Widowed 4 ☐ Divorced **Black** Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Saulsbury Brothers Line Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Carol M. Wells Clara Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5989 Old Trappe Road, Trappe, Maryland 21673 Mark W. Riley / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05-13-2006 Centreville, Maryland Hatchett Road Cem. 22. Name and Address of Facility
Bennie Smith Funeral Home 426 Dover Street, Easton, Maryland 21601 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Chronic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Day in the past 12 months? 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 6 Seule de 2□ No 1 Yes 2 No 25 Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Vivirsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred And Hospital or Attending P 24 hours after death. Funeral Diractor: After to Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

To the Vithin 2

29b. Signature and title of certifier

11.4. Wenn

DHMH 17 Rev 1/2001

29c. License number

Ave, Chestertown

29d. Date signed (Month, Dey, Year)

and manner stated.

415 Washington

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State State Registrer		artment of Health and rtificate of Death	Mental Hygie	E 0 0 0	16463
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici		Goldia l	Ruth Roberts		Month May 1	Day Year 2006	2115 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and it		4b. City, Town, or Location of Deat	h	4c. County of Death	1
			Laurelwood Care Cente	r	E1kton		Ceci1	
I	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🏋 F	7. Age (In yrs. last birthday, 96 Yrs.	If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min.		9. Birth Con 1910 Vir	place (State or Foreign intry) ginia
	pur M		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	Aaryli I sho	ō		E1kton				1 ☐ Yes 2 🔀 No
	289-	Directo	Maryland   Cecil  10e. Street and Number	LIKCOII	10f. Zip Code	10g	. Citizen of What Co	untry?
	3e or		560 Middle Road		21921		United St	ates
	ms 2	Funeral	11 Marital Status 12. Was D	ecedent Ever in U.S. 13. Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Amer	ican Indian,
9	or Ite			s 21☑No	1 ☐ Yes 2 ☒ No Specify:	to rican, etc.)	Black, White	
2	urel',	d by	3 X Widowed 4 □ Divorced Year of	Dates:			Wh	ite
ភ្ន	"net	lete	15. Decedent's Education (Specify only highest grade complete	d) (Give	edent's Usual Occupation a kind of work done during most of wo DO NOT use retired)	rking 16	o. Kind of Business/I	ndustry
7	filed within 72 hours after death with the Maryland Hygiene. wher then "neturel", or Items 23e or 28e-1 show ant, the Madical Ever in the netitied at	Completed	Elementary/Secondary (0-12) College	(1-4or 5+)	omemaker		In Her Own	. Home
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au	should be nd Mental marked c	To B	Townsend Huff		Eva Le	ee		
a	s ma	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street and Number or R	ural Route Number, C	ity or Town, State, Z	ip Code)
Σ.	and 2 palth n 27		Barbara Coale-Moore/D		Telegraph Road,			
ore	Pages 1 nent of Ho nnt: If iter ury or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Removal from	m State 20b. Place of Disp	osition (Name of matory or other place) ill	19,	c. Location - City or 1	own, State
Ē	tent:		'4 ☐ Donation 5 ☐ Other (Specify)	⊢Methodis	t Cemeterv   ZUC		erry Hill	, Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or litems 23e or 28e-1 show eny injury or other treumatic event, in a Madical Exerciting final be notified at once.		21. Signature of Funeral Service Licensee	· HÍ	2 Name and Address of Facility ICKS Home for Fur O3 W. Stockton St	erals, P.A reet, Elkt	con. Marvl	and 21921
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	it caused the death. Do not en	iter the mode of dying, such as cardia	c or respiratory arrest		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	POLLUZE TO	> THLILE			Onset and Death
	/Medical		resulting in death)	to (or as a consequence of):	E Demosi			
100	Examiner		Signantially list conditions, b	to (or as a consequence of):	E Demosi	3		
	ed set	Examiner	E iquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of).				
	al-trai	xar	that initiated events c.	to (or as a consequence of):				
8760,	icate be executed physician and s the burial-transit	dical E	d					
9	tificat ng phy as th	fedi						
Вох	leath certific attending p	an/N	230. Was decedent pregnant	outcome of pregnancy e birth 2  Fetal death 3i	□Ectopic pregnancy		23d. Date of deli	very Day Year
O. E	The law requires that the death certific ate has been signed by the atlending p page 2 should be detached for use as	Physician/Me	in the past 12 pronths? 4 □ Pro 1 □ Yes 2 □ No 9 □ Unknown		Other (specify)		WORL	Day rous
۵.	that the de led by the a detached f	Phy	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ds,	signed I	d by	, <u></u>	<b>3</b>		1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknown
Ö	w requir been si should	lete				24a. Was an	24b. Were aut	opsy findings available
Re	he lav e has age 2	Completed				autopsy	prior to c death?	ompletion of cause of
ta	icien: Th	0	25. Was case referred to medical		26. Place of De	ath (Check only one)	No 1 ☐ Yes	ZLJ NO
$\leq$	ysicien: The is certificate hadirector, page	0 8	examiner?  1 Yes 2 No Hospital: 1	☐Inpatient 2☐ER/Outpatie	Other	Home 5 Residenc	e 6 Other (Spec	ify)
0	ng Phys ter this neral di	n: T	27. Manner of Death  1. Natural 5 Pending (N	te of Injury 28b. Time (		28d. Describe how		
<u>S</u>	uttendir death. ctor: Al y the fu	catic	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	of or Attending after death. Director: After din by the funer	Certification:	datamined ABC. Fi	ace of Injury · At home, farm, silding, etc. (Specify)	treet, factory, office	28t. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	Medical C	(Check only 2 Medical Exeminer: On the		th occurred at the time, date and plac nvestigation, in my opinion, death occ			
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month	, Day, Year)
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	il		30. Name and address of person wind completed c	ause of death (Item 23a) (Type	, Print)	1		102 -
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	Sta Regist		31. Date filed (Month, Day, Year) MAY 2 4 2006	Registrar's Signature	sele?			

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Department of health and Menial Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show sty highly or other traumatic event, the Medical Examination must be notified at once.	by Fu	1 ☐ Never Man		If Yes	es 2 N s, Give or Dates:	10		1 ☐ Yes 2		Specify					ity: Bla	
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46	· · ·	Ų,	Decedent's Name (First, Middle, Last)						aath	3. Time of Death	
	Physici /Medic		SUSAN JANE SKIPTON						2006	11:00 p M	
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death						4c. County of Death		
			Anne Arunde			Annap If Under 1 Year		24 Hzc		e Arundel	
	Funeral Director	X I	5. Social Security Number	6. Sex 7. / 1 ☐ M 2 ☑ F	Age (In yrs. last birthda Yrs.	Months Days	Hours	Min. (Month, Da	ay, Year)	Birthplace (State or Foreign Country)	
1			213-56-9660 Usual Residence of Decedent		56			Dec. 4	, 1949	Maryland	
	thin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f ahow Madical Examinet must be nutified at		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits	
		To Be Completed by Funeral Director	Maryland Anne	Arunde1	Arnol	d				1∑Yes 2 No	
			10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?							Vhat Country?	
			614 Oakland				012			S . A . e - American Indian.	
			11. Marital Status  1 ☐ Never Married 2 ☐ Marri	12. Was Deceder Armed Force ned 1 ☐ Yes 2 5	s?	If Yes, specify Cub	an, Mexicar	gin? (Specify Yes or No n, Puerto Rican, etc.)		ck, White, etc.	
39			3 ☐ Widowed 4 ☑ Divorced Year or Dates:		_	1 ☐ Yes 2 ☒ No	Specify:		Specify	White	
9			15. Deceden	it's Education st grade completed)		edent's Usual Occup		t of working	16b. Kind of B	usiness/Industry	
21	within ene.		Elementary/Secondary (0-12)	College (1-4c	or 5+)	DO NOT use retire	d)	e or working			
21	ygy ygi		47.50 1.11 (5) 1.16(4)	2	R.	N. Nurse	40.14-4	(C) - A(1)		spital	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed. Department of Health and Mendral Hyg. Importent: If Item 27 la marked othe any injury or other traumatic avent, QDCs.		17. Father's Name (First, Middle,	,			Ma	ar's Name <i>(First, Middle</i> ary McLaugh	lin	l <b>e</b> )	
Ž			Ray Kennedy  19a. Informant's Name/Relations			iling Address (Street		Hary McLaug er or Rural Route Numb		State Zin Code)	
Ma			Mary M. Skipto							otomac, MD 20878	
ē,			20a. Method of Disposition	in mounci	20b. Place of Dis			Date		City or Town, State	
E			1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (S		10	itan Cremato		05/11/2006	Alexan	dria, Virginia	
Baltimore,			21. Signature of Funeral Service	Licensee			ss of Facili	Gasch's	Funeral	Home, P.A.	
	8958		Jalust C	May		4739 Balt	timore	Avenue, H	yattsvil	le, MD 20781	
4	Physician		23a. Parti. Enter the disease, or shock, or heart failure. List	r complications that caus only one payse on each	sed the death. Do not e	nter the mode of dyir	ng, such as	cardiac or respiratory a	rrest,	Approximate Interval Between	
			Opent and Death								
	/Medical Examiner	Examiner	resulting in death)	Due to (or a	as a consequence of):	,					
2	cate be executed physician and the burial-transit		Immediate Causa (Final disease) or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
			if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):								
Ć.		Еха									
8760,		dical	d								
9	ntitica ng ph as th	Med	IE EEMALE:								
Вох	eath certitic attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □						23d. Date of delivery  Month Day		
0	at the dea by the al	/sic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown						Month Day Year		
Δ.	that the ed by delac								23e. Did tobacco use contribute to the cause of death?		
	ding Physicien: The law requires n. Atter this certiticate has been sign funeral director, page 2 should be	ompleted by	acute renal failure.						1 Yes 2 No 3 Probably 4 Unknown		
								24a. Was	24a. Was an 24b. Were autopsy findings available		
Re								auto perfo	psy prmed? c	prior to completion of cause of death?	
Division of Vital Records,		C	25. Was case referred to medica	ı ı			26. Place	1 ☐ Yes of Death (Check only)		I ☐ Yes 2 ☐ No	
		To B	a examiner?								
		catic	2 ☐ Accident investi	gation	No	ı					
Ξ̈́		Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location ( City or To	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
			29a. Certifier Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	Ho 24 h Fur stely	edicai	(Check only 2 Medical one)	Examiner: On the basis and manner	of examination and/or	investigation, in my o	ne, date an pinion, dea	th occurred at the time,	date and place,	and due to the cause(s)	
	To tha vithin 2 To tha c. mplet	Me	29b. Signature and title of certifie	$\sim$		29c. Licens	e number		29d. Date signed	d (Month, Day, Year)	
			1 Strek (10-1 DS8510						05/08/06. edical PK-WY, Annapolis Mo		
12	(4)		30. Name an address of person	who completed cause of	f death (Item 23a) (Tpp	e, Print)	<i>(</i> ) -	1 3 1 1	( 0)	1 1 1	
1	0		Stephen	· Olexa	2A	AMIC	400	) I Medica	1 PKN	4, Hunapolis Mo	
	Sta Registi		31. Date filed (Month, Day, Year)	2. Regis	strar's Signature	de .					
*	(C) 10913(1		MAY 1 1 2	UUU AA						1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Betty Ann Smith May 6, 2006 1755 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges Community Hospital Cheverly Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number , Funeral 1□M 2 🕌 20, 213-42-6796 64 1942 Washington, D.C Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County ral', or items 23a or 28a-f show Experies must be coulded at 17 Yes 2 No Director Maryland Prince Georges Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6826 Walker Mill Rd. Apt. 202 20743 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Tyes 2 ⊠No fYes, Give 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Black Specify: δ 3 ☐ Widowed 4 ☐ Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Federal Government and Mental Hygie 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Smith Anne Davis 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 nent of Health a ant: If item 27 Is ury or other trai 5901 Middleton Ct. Temple Hills, Md. Danita J. Smith / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. May 11, 2006 Clinton, Md. Resurrection 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice ²²Alexander S. Pope Funeral Homes, P.A. 40103 5538 Marlboro Pike/Forestville, Md. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Respiratory Failure /Medical Due to (or as a consequence of) **Examiner** Acute Pulmonary Embolus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Cardiac Asystole 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No 2 No 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 20 No 2 ER/Outpatient 3 DOA ipis L funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1X Natural 1 Yes 2 No М 2 Accident after death Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760,

with the Maryland

death v

Baltimore, Maryland 21215-0036

31. Date liled (Month, Day, Year) State MAY 1 1 2006 Registrar

29a. Certifier

(Check only one)

29b. Signature and title of gertifier

Medical



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D28195

29d. Date signed (Month, Day, Year)

May 10, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#26 PER PHYS. G856 6/19/06 WS

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8, 2006 Ray Sumter May 5:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Laurel Regional Hospital Prince Georges Laure1 | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Months Days Hours Min. | Min. | 1 1 - 16 - 1931 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X**]M 2□F 74 Yrs. 250-44-0287 Director So.Carolina Usual Residence of Decedent the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event. The Medical Exercical must be notified at once. 10a. State 10b. County 10d. Inside City Limits tv Yes 2 □ No Director PrinceGeorges Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20735 8306 Deerstill Way USA by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married A Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: **Black** Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cement Finisher Private Industry 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ella Goodwin Joseph Sumter 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8306 Deerstill Way 19a. Informant's Name/Relationship (Type, Print) Mary Ann Sumter (Wife) Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 05/16/2006 Riverdale, Md. 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crem. of Funeral Service Licenses 21. Signature 22. Name and Address of Facility Ralph Williams Funeral Service Willes 767 1813 Potomac Ave., SE; Wash., 20003 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease Yrs. Many /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (u. as a consequence of) Examine The faw requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably **¾** ☐ Unknown Chronic Atrial Fibrillation, Hypertension Clot in Left Atrium, Anemia, Chronic Renal 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an page 2 s autopsy performed? Failure certificate 1 Yes 2 No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 Nnpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) After thi 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Matural 2 ☐ Accident 5 Pending ler death. irector: Al investigation М 1 Yes 2 No 6 Could not be determined To the Hospital or Atte within 24 hours after dex To the Funerel Directo completely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5/8/2006 D23181 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1704 Gorman Ave., #T-1 Laurel, Md. 20707 G. Bhojraj, MD 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 1 2 2006

# Please Type or Print in Black Indelible Ink

athan Spann		State of Maryland / Department of H  1-For State Certificate of D  Registrar			g. No. 200	15 1546				
Physicia dical Exami	an/	Decedent's Name (First, Middle,Last)     Jonathan Ray Spann		2. Date of Death Month May 9, 200	Day Year	3. Time of Death 2103 hrs				
and to		4a. Facility Name (if not institution, give street and number)  4b. 6	City, Town, or Location of Death  4c. County of Death							
- Funanti		Joseph January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary January, Mary Mary January, Mary Mary Mary Mary Mary Mary Mary Mary	anham Under 1 Year I If Und	der 24Hrs 8 Date of Birt	Prince Georg					
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any		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location				10d. Inside City Limits				
·land -f show once.	to	MD Prince Georges Lanham	V 7: 0.4	147	ng. Citizen of What Cou	1 X Yes 2 No				
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D 14. Married Forces? 1 Yes 2 No	ecedent of Hispanic Or specify Cuban, Mexica	igin? ( Specify Yes or No- n, Puerto Rican, etc.)	- 14. Race - Ame White, etc.	rican Indian, Black,				
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5-003 ed withii tygiene. orher the	Comp	12 years 2 years 17. Father's Name (First, Middle, Last) Billy Spann	18 Mothe	er's Name (First, Middle, N	Maiden Surname)					
1215 d be file fental H arked	Be (	· · ·	abor City or Town Stat	o Zio Codo)						
MD 2 2 shoul th and M 27 is m umatic	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  9121 5th. St. Lanham, MD. 20706								
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/Medical		foure. List only one cause on each line.  Immediate Cause (Final disease a Complications of morbid obesity  Between Onset and Death  Death								
zadiiiiioi		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.								
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tox 68760, eath certificate be executed a attending physician and for use as the burial - transit	an/Me	FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal	death 3 Ectop	pic pregnancy	23d. Date of delive Month	ry Day Year				
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The law requires that the forest after death. The law seen signed by the attending physician and phyletly filled in by the funeral director, page 2 should be detached for use as the burial - transi	ysician/I	1 Yes 2 No 9 Unknown 9 Unknown	(Specify)		8					
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F Vit	100	1 V Yes 2 No Inpatient 2 ER/Outpatient 3			Residence 6 Othe	er:				
on of anding Plath.		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury (Month, Day, Year)	1 Yes 2	_	now injury occurred					
Division of North Hospital or Attending Physician 24 hours after death. To the Funeral Director: Affert Completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, to	actory, office building,	etc. 28f. Location (S or Town, S		ural Route Number, City				
Hospital A hours Funeral										
To the I within 2 To the I	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	and place, and due to t	he cause(s)						
	Σ	29b. Signature and title of certifier	O.C.M.E.	#I	29d Date signed (Mi	ontn, Day, Year)				
		30. Name and address of person who completed to of death (Item 23a)								
2(6)		20 Paristrate Circuit	Street, Baltimore	e, MD 21201						
Regi:	State									

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 4.56 PM 9 Euro MAY 2006 >EABOCT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BANMUE Musica Cura UNIVERSITY OF MANYCAM Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 M 2 F 246-08-5459 Director 4-11-1957 Massachusetts Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Menial Hygiene. Importent: if item 27 is marked other than "natural", or iteme 23a or 28a-f ehow amy injury or other traumatic event, the Madical Examinar must be confilled at one. 1 ☐ Yes 2 PNo Director MD St. Mary's Leonardtown 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 44220 Richey Road 20650 United States Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 EYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Aircraft Mechanic U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George William Seabolt ပ Betty Louise Chace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44220 Richey Road, Leocardtown, Maryland 20650
Date 20c Location - City or Town, State Kelcy Seabolt/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition t ■ Burial 2 Cremation 3 Removal from State Arlington National 6-21-2006 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Se 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward W. Brinsfield, 22955 Hollywood Road, Leonardtown, Maryland 20650 M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** HYPOXIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MELOSENOVS 1 EVICEMIA TYEAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a or nsequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, attending physicien Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Tilleknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1 K Inpatient 2 ER/Outpatient 3 DOA Certification: To Pis 27. Manner of Death ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation efter death. Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e To the Funeral E 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated ŝ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

MAY 1 8 2006

31. Date liled (Month, Day, Year)

MICHARL

ABRAHAM

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



S. GREENE

P19646

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2000

DHMH 17 Rev 1/2001

			For State Registrar	State of Mary		artment of F			giene Beg. No. 006	16470
		Ž.	Decedent's Name (First, Middle, Last,	)				2. Date of De.	ath	3. Time of Death
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	/Medic Examir	-46	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Dea		4c. County of Dea	
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	pu .		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	ncation				10d. Inside City Limits
	sho	5			_					1 ☐ Yes 2 ☐ No
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	iter d	F.	1 ☐ Never Married 2 ★ Married	Armed Forces? 1 ☐ Yes 252 No		Was Decedent of H If Yes, specify Cub.	an, Mexican, Pue	rto Rican, etc.)	Black, Whi	
21215-0036	be filed within 72 hours after death with the Maryland nal Hygiene. nd other than "natural", or Items 23s or 28s-f show event, the Medical Examinat must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2⊠No	Specify:		Specify:	White
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	filed within Hygiene.	Son		4	Syste	ems Desig			Computer Te	echnology
Ind	tal H d off	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	
yla	should be filed withir of Mental Hygiene. marked other than imatic event, the M	٦ و	Harold H. Stout					rtrude M		
Maryland	2 8 8		19a. Informant's Name/Relationship (T) Rebecca Stout / Williams						er, City or Town, State,	
	is 1 and 27 item 27 other tra		20a. Method of Disposition					Date	on, MD 2175	
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Baltimore,	it. Pz irtmer irtent njury		4 □Donation 5 □Other (Specify)  21. Signature of uneral Service Licens			Cremato			Frederick,	
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00	w requir s been si should	Completed						24a. Was		utopsy findings available
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<u>&gt;</u>	Physicien: this certificatal director, I	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1   Inpatient	2 ER/Outpatie	nt 3 DOA Ott	ier: 4 🗆 Nursing		dence 6 □Other (Spe	ocify)
οr	ding Ph h. After th funeral		27. Manner of Death  1. ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	f 28c. Injui Wor	y at	28d. Describe t	now injury occurred	
Ö	Attending ir death. ector: After by the fune	atic	2 ☐ Accident investigation		,		Yes 2 □ No			
Division	or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S)	At home, farm, st pecify)	reet, factory, office		28f. Location (5 City or Tox	Street and Number or R vn, State)	ural Route Number,
	urs af									
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my ner: On the basis of exa	/ knowledge, deat mination and/or in	h occurred at the til vestigation, in my o	me, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	thin 2 the omple	Mec	29b. Signature and title of certifier	and manner stated.	. 14	29c. Licens	se number		29d. Date signed (Moni	th. Dav. Year)
	E 2 E 3		<b>)</b>	000	MD	A	16675			, 2006
1	3		30. Name and address of person who or	ompleted cause of death	(Item 23a) (Type	Print)				, 2000
-		1	Warne and address of person who do	Muchier	2	3 RUNSWIC	in t	10 21	1716	
1	Sta		31. Date filed (Month, Rey, Year)1 2	32. registrar's 5	Signature	JRUNSWIC	,			
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State of Maryland / Department of Health and Mental Hygienen - State Registrat Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 8,2006 Year **Physician** 2:45a Skelly Antoinette /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Olney Montgomery Montgomery General Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 11/06/1918 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 1 F 87 West Yrs. 232-05-4805 Virgini Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itema 23s or 28s-f ehow any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Silver Spring MD Montgomery 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 3501 Fiske Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Gallo Samuel Iaquinta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1029 19a. Informant's Name/Relationship (Type, Print) 13170 Brighton Dam Road Clarksville, Md Patrick M. Skelly/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Rem pval from State 5/15/06 Silver Spring, Md Gate of Heaven 4 □ Donation 5 □ Other (Specify) 21. Signaturion Funeral Service Licensee PHONE TO PANDES MENALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer mo. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit signed by the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pneumonia, coronary artery disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown urinary tract infection, anemia 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy performed? 2 X No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainler as stated.

2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D18726 May 8,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Authur Schoengold HD 18101 Prince Philip Dr.O.ney, Ma 20832 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 10 2006 Registrar

# Please Type or Print in Black Indelible Ink

aunew Stegma	1	State of Maryland / Department of Health a -For State Certificate of Death	ind Mental Hy		200	6 1647
Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	1	3. Time of Death
ledical Examii		MATTHEW GEORGE STEGMANN  4a. Facility Name (if not institution, give street and number)  4b. City, Town,	or Location of Death	Month May 15, 20	4c. County of Death	2215 hrs
		18335 Lost Knife Circle, #304 Gaitherst			Montgomery	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y Months D	Year If Under 24Hrs.	-	h(MM/DD/YYYY) 9. Bir	in .
Director		219-15-1392 12 M 2 F 23 Yrs.	ays riours with	03/06		untry) MD
any	-	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location		-		10d. Inside City Limits
<u>*</u> ,	5	MD MONTGOMERY GAITHERSBURG				1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code		10	g. Citizen of What Cou	ntry?
vith the	_	18335 LOST KNIFE CIRCLE, #304 206  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of	886 Hispanic Origin? (Sp.	ecify Yes or No-	USA 14. Race - Ameri	can Indian, Black,
death v rritem	Funera	1 Never Married 2 Married Armed Forces? If Yes, specify Cul	ban, Mexican, Puerto		White, etc.	
s after iral", o	by	3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occu		ork done	Specify: WH  16b. Kind of Business/	
136 hin 72 hours aft e. than "natural" edical Examine	eted	Elementary/Secondary (0-12) College (1-4 or 5+)			Tob. Tang of basiness/	,
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MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f she numatic event, the Nedical Examiner must be notified at once	Be Co	17. Father's Name (First, Middle, Last) FRANK CHARLES STEGMANN	18.Mother's Name	(First, Middle, M		
ould by Ment S mark	10	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (St	treet and Number or R	tural Route Num	ber, City or Town, State	
MD and 2 sho salth and 2 ris		FRANK STEGMANN / FATHER 19721 MID 20a. Method of Disposition (Name of	cemetery	Date	20c Location - City or	Town State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Nedical Examiner.		1 Burial 2 Cremation 3 Removal from State FREDERICK CRE	MATORY 05	5/18/20	06 FREDE	RICK, MD
altin mit. Pa partmer portan ury or		4 Donation 5 Other Specify:	ress of Facility FUNERAL I			
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyl	X 86. BAI	RNESVII	LE, MD	20838 Approximate Interval
Physician /Medical	Í	failure. List only one cause on each line.	ing, such as cardiac of	respiratory arre	ssi, shock, of fleat	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Asphyxia due to Hanging  Due to (or as a consequence of):				
	<u>.</u>	Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):				-
	Examiner	Co. Chisease or injury that initiated				
executed an and al - transit		events resulting in death) Last Due to (or as a consequence or):  d.				
be exection a sician a urial - 1	Medical	UNPENDED				
8760, tificate b		IF FEMALE: 23b. Was decedent pregnant in the 2. Second of pregnancy 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregna	ıncy	23d. Date of deliver Month	y Day Year
cords, P.O. Box 68760, aw requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transit	Physician/	past 12 months?  1 Yes 2 No 9 Unknown  1 Unknown  1 Dregnant at time of death 9 Unknown  5 Other (Specify)				
O. B. tr the de by the ached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cau	se given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
i, P.O.	d by			1 Yes	2 <b>V</b> No 3 Pro	bably 4 Unknown
ords w requ as been	Completed			24a. Was a autop: perfor	sy prior to	utopsy findings available completion of cause of
tal Reco rian: The law certificate has	Com			1 Yes		es 2 No
'ital sician: is certi	a	examiner?   Hospital:   Inpatient 2   ER/Outpatient 3   DOA	Other: Nursin		Residence 6 V Othe	r: Scene
ing Physi ing Physi After this	n: 1	(Month, Day, Year)	Injury at Work?	28d. Describe h Subject four	now injury occurred	
sion ttendin death rtor: / y the fi	atio	Accident Investigation May 15, 2006 2137 hrs	Yes 2 V No			
Division of Vital Records, tal or Attending Physician: The law requir rs after death all Director: After this certificate has been siled in by the funeral director, page 2 should t	Certification:	3 ✓ Suicide 6 Could not be determined (Specify) Multi-Family Apt.	ce building, etc.	or Town, S		ural Route Number, City nersburg, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time		due to the caus	e(s) and manner as sta	ted.
To the within. To the comple	Medical	one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	nion, death occurred a	t the time, date		
	Σ	25b. Signature and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of	.C.M.E.		29d. Date signed (Mo	mur, Day, rear)
	30. Name and address of person who completed cause of death (Item 23a)					
3		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Balti	imore, MD 21201	1		
S	tate	31. Date filed (Month Valcy'ea4 2006 3 Registrar's Signature				

		_ For	State of Maryla	ınd / De _l	partment of H	Health an	•		•	161.73
		1 - Stete Registrar		C	ertificate of	Death		Reg. No	2.000	10410
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/Med	ical	John			14	man	NIG	19	3006	
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		Usual Residence of Decedent					1100 23	, 15.	)   Fici.	yiana
rylan		10a. State 10b. County		City, Town or	Location					10d. Inside City Limits
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within 16.	E G	Elementary/Secondary (0-12)	College (1-4or 5+)					DI	3DCC	
Hygie Thar	e Co	12th 17. Father's Name (First, Middle, Last)		met	er tester		Name (First, Middle		IPCO Sumame)	
Mental Mental Irkad o	To Be	John Marvin Tayman,	Sr.			Mary	7 Hobbs			
politiniole, Mar yiallia AIA 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any niury or other traumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship (Type, Mary Ann Tayman - W.			ailing Address <i>(Street</i> Mermaid Ct				or Town, State, Z	(ip Code)
F Hear Hear othan	1	20a. Method of Disposition	20b.	. Place of Dis	position (Name of rematory or other pla	COL 34-L- 1	Date	20c. L	ocation - City or	Town, State
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mint.	i.	21. Signature of Funeral Service Licensee			22. Name and Addre		_			
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THE STATE		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused the de	ath. Do not e	enter the mode of dyir	ng, such as car	diac or respiratory a	rrest,	mirc Ma	Approximate Interval Between
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uires uires sign	d by						10	Yes 2	□No 3□Pro	obably 4 Unknown
v requ	ete						24a. Was	20	24h Word 200	topsy findings available
The law requirate has been spage 2 should	Completed						auto			completion of cause of
VICIAN: The lavinitizate has rector, page 2	င်	25. Was case referred to medical				00 DI (	1 Yes		1 ☐ Yes	2 No
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ding Physician: n. After this certific funeral director.	I		28a. Date of Injury	28b. Time	of 28c. Injur	ry at	28d. Describe			ary)
ading F nding F th. : After s funera	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		rk? ∣Yes 2 ∐No				
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s afte	Certification:	4 D Homicide	building, etc. (Spec	спу)			City or To	wn, State	))	
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FSFO		Wguyen MEDICA	L DOCTOR		150	-mn		MA	16 16	7001
		30. Name and address of person who comp	pleted cause of death (It	em 23a) (Tvn	e. Print)	000	,	1119	4 10, 6	200
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St Regist	ate trar	31. Date filed (Month, Day, Year)  MAY 11	pleted cause of death (It	rature J.	Spelle				I {	

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1 - For State Registrar

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	Physici	an	1. Decedent's Name (First, Middle, La KENNETH RO	· ·	DE			2. Date of De	ath Da		1	of Death
	/Media		4a. Facility Name (If not institution, giv		NC.	4h City Town	or Location of Deat	May	40	2000 County of Deat		12 M
	Examir	ıer	University of Mary		Center		more			JIA		
	Funeral		5. Social Security Number 6. 5	Sex 7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs	8. Date of Bir	rth	9. Birt	hplace (Stat	re or Foreign
	Director		020 02 70.0	t ^{□ M 2 □ F} 63	Yrs.	Months Days	Hours Min.	March 2	22,	1943 _{Mass}	sachus	etts
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					10d Inside	City Limits
	Maryli 1 eho	ō			ifornia							es 2 No
	28a-	Director	Maryland St. Mary 10e. Street and Number	7's [Call	LTOTIIT	10f. Zip Code			10g. Cit	izen of What Co	l	
	h with	0	23552 Gross Drive	2		20619			Unit	ted Stat	ces	
	be tied within 72 hours after death with the Maryland all Hygiene. All Hygiene death with the Maryland state of the the model Examinat must be notified at event. In Medical Examinat must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decedent of H	Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No	0+	14. Race - Ame Black, White		
0	or it	by Fu	X Never Married 2 Married	1 ☐ Yes Ži ☐ No If Yes, Give		1□Yes 2ŽNo		10 71104171 (10.1)		Spacific		
Ś	hours turei'		3 Widowed 4 Divorced	Year or Dates:	16a Dass	death Herel Occur			10) 16	WI	nite	
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7	d with giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) <b>5+</b>		e Biologi				oratory		
2	e file al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last	)				me (First, Middle	, Maiden	Sumame)		
2	Menta Menta arked	2	Louis Tenore				Esther	Fallon				
2	and and is ma		19a. Informant's Name/Relationship (	Type, Print)			t and Number or Ri					
5 5	l and lealth im 27 her ti		Elizabeth J. Ten			Locust Fe	ence Rd.,	Dataw I				
5	Pages 1 nent of P int: if ite iry or ot		20a. Method of Disposition 1 ☐ Burial 【☐ Cremation 3 ☐	Removal from State	cemetery, crer	natory or other pla				ocation - City or		
	그 문 관 분		4 □Donation 5 □ Other (Special Signature of Funeral Service Lice)		tropol:	itan Cre	natory 5/	12/06		xandria		jinia
0	Dep Impo		21. Signature of Fuller at Service Co.	#			s Island Ro					676
6			23a. Part1. Enter the isease, or com	plications that caused the deat							Approxim	nate
	Physician		shock, or heart failure. List only Immediate Cause (Final	All a marks							Onset an	nd Death
	/Medical		disease or condition resulting in death)	a. Hypoxia.  Due to (or as a conseq	uence of):							uys.
ч	Examiner		Communication for more fations	Myocardi	al IV	rfarct10	n				2 d	ays
- 4-	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):						2 d	06
	ecute and trans	Examiner	that initiated events resulting in death) Last	c. Pancrat  Due to (or as a conseq	7175						18 00	143
S,	be ex icran burial	al E		Due to (or as a conseq	uerice di):							
000	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	an/Medical		_ d.								
4	n certi	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna						23d. Date of deli	ivery	
2	death e atte	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of d		JEctopic pregnanc Other <i>(specify)</i> _	у			Month	Day	Year
)	at the by th tache	Physici	9 🗆 Unknown	9□ Unknown				-				
'n	es tha	by	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.		9	use contribute to		
5	w requir been si should	Completed				·		1 🗆	Yes 2)	No 3□Pr	obably 4 [	□Unknown
ט ט	s faw has b	nple						24a. Was auto	psy	24b. Were au	topsy finding completion o	as available if cause of
E .	: The	S						1 Yes	2 No	death?	2 ☐ No	
, T	rsician: The law s certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Ott	200	ath Check only		_		
5	Phys rthis ral di	. To	1 Yes 2 No 27. Manner of Death	1 ✓ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatien 28b. Time of	3 DOA	4   INGISHING F	lome 5 ☐ Resi 28d. Describe			ofy)	
5	l or Attending i after death. Director: After I in by the funer	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Injury	Wo	rk? ]Yes 2 ∐No			,		
2	Atter	Hca	3 Suicide 6 Could not b	200. Place of injury - At he	ome, farm, str	est, factory, office		28f. Location (	Street an	d Number or Ru	iral Route N	umber,
5	tal or s afte ai Dir ed in	Certification:	4 - Homicide	building, etc. (Specif	γ)			City or To	wn, state	,		
	To the Hospital or Attending Physician: The faw requires that the death certificate be executed within 54 hours attent death.  To the Funeral Director: Attenthis certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying Ph	nysician: To the best of my kno miner: On the basis of examina	wledge, death	occurred at the til	me, date and place	e, and due to the	cause(s)	and manner as	stated.	0(s)
	the hin 24 the F	Medi	one)	and manner stated.								
	o T wit	-	29b. Signature and title of certifier	<i>)</i>		29c. Licens	se number		290. Dai	te signed (Monti	1, Day, Year,	) 1
•			30 None of 1	completed a visa of the the	n 02a\ /T	Av4	176435		5/	7/6	criay.	t, 2006)
^	20		30. Name and address of person who	completed cause of death (Item	11 23a) (1ype,	DACTIV	none m	1 212	، ن	·		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrans Signa	ature				- /			
	Registr		MAY -	completed cause of death (Item 2	J. S.	April	9					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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ROBERT TIFFANY

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If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, it a Maxical Examiner must be notified at filed within 72 hours after death and Mental Hygiene. and 2 should be ealth and Mental permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or othar trau Pnysician

/Medical Examiner igned by the attending physician and be detached for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 signed by Attending Physician: this After death. after death ö To the Hospital o within 24 hours aft To the Funeral Di

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ROBERT MCCLELLAN TIFFANY 5 MAY 2006 3:35AM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner TALBOT HOSPICE HOUSE EASTON TALBOT | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | OCT 14, 1919 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** NEW YORK 127-03-4070 86 Yrs Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No CT NEW HAVEN SOUTHBURY Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 322A HERITAGE VILLAGE 06488 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 May Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LUMBER BROKER LUMBER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLAYTON W. TIFFANY MAE G. HEFFERNAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY E. TIFFANY CROSS/DAUGHTER 39 WOODBINE AVE., LARCHMONT, NY 10538-3522 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State CHESAPEAKE CREMATION CTR 5/6/2006 1 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ercbrovascu/ar month Due to (or as a consequence of) upertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 3ENO 1 🗆 Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 242816 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 Cynwin 31. Date filed (Manth . Registrar's Signature

State

Registrar

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			For State Registrar	State of Ma	arylan		artment o			and Me		giene () leg. No.	) 6	64/6
	Physicia /Medic	al	Decedent's Name (First, Middle, La	TTE		TZ	0D/ 4b. City, Tow	K (	OV ocation o		2. Date of Dea Month MAY	Day	Year 2006 of Death	3. Time of Death 2°45 HM
	Funeral	er	Hebrew Home of (	Greater Was		ton last birthday) Yrs.	Rocl	kv i		24 Hrs.   6	B. Date of Birth	,	gomer 9. Birthp P <b>642</b>	ace (State or Foreign
		tor	Usual Residence of Decedent 10a. State 10b. County MD Montgom			y, Town or Lo					10d. Inside 0			
	th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 6111 Montrose Re	d. #310			10f. Zip Coo 2 0	de 1852				10g. Citizen of USA		try?
7036	Pages 1 and 2 should be filed within 72 hours a ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", o ury or other traumatic event, It a Mindfall Example.	þ	11. Marital Status  1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ X If Yes, Give Year or Dates:		1	Was Decedent f Yes, specify (		panic Orig Mexican Specify:	gin? (Spec i, Puerto Ri	ify Yes or No- ican, etc.)	Specif		etc.
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altımore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Speci	fy)	1 0	Monte:	sition (Name of matory or other E <b>iore</b> C	cem .	M		2006	Farming		
21. Signature of Funeral & one lineare Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC  23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,									DC 2	0012				
	cate be executed hysician and hysician and Examiner transit the buriar-transit	Examiner	23a. Part: Enter the disease, or consistency, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	a censeque	uence of):	SNAL	/	FA	1211	RE	ON		Approximate Interval Between Onset and Death
.O. Box 68/60	ath certific ttending p or use as	Physiclan/Medlca	IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/hths? 1   Yes 2 Mo 9   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unknown   Unkno										te of delive	ry Day Year
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			For State Registrar	State of M	laryland /	Depa Cer	artment rtificate	of H	ealth a	and M		giene Reg. No.	200	6	16	:77
			1. Decedent's Name (First, Middle, Li	ast)							2. Date of De Month	ath Day	Y	ear	3. Time o	f Death
	Physicia /Medic		GEORGETTE	L.	T	YLE	R				May	2 -	2006		1:4	2P M
	Examin		4a. Facility Name (If not institution, gi	ve street and number			4b. City, T	own, or	Location o	of Death		4c.	County of			
			Holy Cross Ho	spital			Sil	ver	Spr	ring			Mont	gon	nery	
	Funeral				ge (In yrs. last b	oirthday)	If Under 1		If Under		8. Date of Bir (Month, Da July29	th V Year)	9	. Birthpla	ace (State	
	Director		217-66-8365	1□M 2XF	49	Yrs.	WOTHERS	Days	riours	Will I.	July29	,19	56	Mar	'ylan	.d
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ė	E U	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	13.	Was Decede If Yes, specif	ent of Hi fy Cubai	spanic Ori n, Mexican	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - Black,	America White, e		
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arylan	marked umatic ev	Ĕ	19a. Informant's Name/Relationship		19	9b Mailir	na Address (	(Street a			A Route Number		r Town Sta	ate Zin	Code)	
Baltimore, Maryland 21215-0036	permit. Tages I and a stock of permit. Tages I and A should limportant; if I tem 27 is marked any injury or other traumatic events.		Christina Oliv										002	SMD	7,202	06 prin
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			shock, or heart where. List ont	y one cause on each	line.	o not ent	er the mode	or dying	g, such as	cardiac	or respiratory a	rrest,			Interval Be	tween
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	h. After I funera	ü	27. Manner of Death  XXNatural 5 ☐ Pending	28a. Date of In (Month, D	lury 28b lay Year)	. Time of		Bc. Injury Work			28d. Describe	how infur	y occurred			
Division of Vital Records,	or: /	Certification;	2 Accident investigation 3 Suicide 6 Could not	he -			М		res 2 □ I							
<b>∑</b>	after deat Director; I in by the	ŧ	4 Homicide determine	A 286. Place of It	njury - At home, etc. <i>(Specify)</i>	farm, str	eet, factory,	office			28f. Location (: City or To	Street an wn, State	d Number ( )	or Rurai	Route Nun	nber,
	within 24 hours after of Ta the Funeral Directorpletely filled in by		722	4		_										
	within 24 hours and the Funeral completely filled	edicai	(Check only 2 Medical Exa	hysician: To the bes miner: On the basis	of examination a	ge, deatl and/or in	n occurred a vestigation,	it the tim in my op	ie, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) date and	and manne place, and	er as sta I due to	ated. the cause(	s)
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Þ	5 1 1 5 E		29b. Signature and title of certifier			MO.	230.		8862			1	0			
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	Ŧ		30. Name and address of person who					a ~	4 1 ·			1.50	000	0.4		
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Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death Reg. No. 2006	647					
Physician/ Medical Examiner	r Frances Thompson Month Day Year 1735 h						
· · · · · · · · · · · · · · · · · · ·	4a. Facility Name (if not institution, give street and number)  Suburban Hospital  4b. City, Town, or Location of Death  Bethesda, MD  Montgomery						
Funeral Director	5. Social Security Number 242-50-9192 6. Sex 1 Months Days Hours Min. 9/22/1934 Foreign Country) 9. Birthplace (State Months Days Hours Min. 9/22/1934 Foreign Country) N. C	c or					
Maryland 28a-f show any 1 at once.	Usual Residence of Decedent  10a. State	•					
ith the Maryland 23a or 28a-f sho notified at once. al Director							
r death wi or items must be	1 3 X Widowed 4 Divorced III Yes Give Year 1 1 Yes 2 X No enocify:	lack,					
5-0036 led within 72 hours after thygiene other than "natural", the Medical Examiner Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  8  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Cook  Restaurant						
	James Lawrence Hicks Effie Wall						
Z d d Z m Z m Z m Z m Z m Z m Z m Z m Z	Robin Graeves/Daughter 3608 John Carroll Drive Olney, Md 2083	2					
imor Pages ment of tant: If or othe	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Dogation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Gate of Heaven  20c. Location - City or Town, State  5/11/06 Silver Spring,						
Physician  Physician  Physician	21. St. June of Funeral Service Licensee  PHILIP D. RINALDI FUNERAL SERVICE, P. F. 9241 Columbia Blvd. Silver Spring, Md2  23a. Part I. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate	<u> 20910</u>					
/Medical Examiner	failure. L'ist only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):						
ner	Sequentially list conditions, if any, leading to immediate  Cause Enter Underlying Cause						
vecuted  1 and  - transit		-					
0, e be earsician burial	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery						
		Year					
i, P.O. B ires that the d signed by the lbe detached d by Phy	Hypertensive Atherosclerotic Cardiovascular Disease						
Division of Vital Records, P.O. Box 68 the Blospital or Attending Physician: The law requires that the death certif hin 24 hours after death the Funeral Director: After this certificate has been signed by the attending appletely filled in by the funeral director, page 2 should be detached for use as dical Certification: To Be Completed by Physician	24a. Was an autopsy findings autopsy prior to completion of competer performed?	available					
tal Recition: The certificate ector, page	25. Was case referred to medical 26. Place of Death (Check only one)	No					
f Vit Physici er this c eral dire	1 Ves 2 No Page 1 Page 1 Page 2 No Page 2 No Page 2 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3 Page 3						
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Divis  To the Hospital or At within 24 hours after d  To the Funeral Direct completely filled in by Medical Certifica	293. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started  one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  and manner stated.						
2 Z	29b. Signature and title of certifier  Pollul Signature and title of certifier  O.C.M.E.  29d. Date signed (Month, Day, Year)  May 9, 2006						
	30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
State Registrar	NULLY TO COOP BY. ANY ALABAMAN						

1.	_ State	State of Maryland		nt of Health and		6000	16479
	Registrar		Oertinea	ile of Death		No.	2 Time of Dooth
Physician /Medical	Decedent's Name (First, Middle, Last) Helen E	1: Zabeth		MS	11.1-1	Day Year 2004	
Examiner 48	a. Facility Name (If not institution, give st	reet and number)	4b. Cit	y, Town, or Location of Deat	h J	4c. County of Death	- /
		reral Hospi	tal Co	er 1 Year   If Under 24 Hrs	D. D. L. of Distr	Workha	514
Director /	80-12-3312	7. Age (In trs. II	Yrs. Months				place (State or Foreign intry) 2r4/and
	sual Residence of Decedent  0a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
5-0036 MM To hours after death with the Maryland To hours after death with the Maryland Inaturel, or items 23a or 28a-1 show disal Examiner must be rotified at eted by Funeral Director	MD Dorch	ester	Cambi	ridge			1 Wes 2 No
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Sa sa sa sa sa sa sa sa sa sa sa sa sa sa	Glenbury	1 Ave, Roul	1207	2/6/3		$_{\mathcal{U}}SA$	
tems ar dea	1. Marital Status	<ol><li>Was Decedent Ever in U.S Armed Forces?</li></ol>	3. Was Dec If Yes, sp	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White	
d 21215-0036 d 21215-0036 lifed within 72 hours after Hygiene, after then "naturel", or flee ant, the Medical Examine e Completed by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes	211 No Specify:		Specify: B. L.	ack
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mort of lary or o	1 ☑ Burial 2 ☐ Cremation 3 ☐ Re  1 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	metery, crematory or Pleasant C	· · · · - /	15/06 M	illington	MD
그는 그 원칙을 되었다.	1. Signature of Funeral Service License		22. Name a	and Address Facility	1 11	illing roi	, M.D.
	Janelle C	. Slevery	) Henn	Jashinaten	St. CAM	bridge. N	10,21613
2	23a. Part . Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death	. Do not enter the mo	ode of dying, such as cardia-	c or respiratory arrest	37	Approximate Interval Between Onset and Death
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	Pa. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☐ Medical Examina	cian: To the best of my know ar: On the basis of examinati and manner stated.	viedge, death occurre ion and/or investigatio	d at the time, date and place on, in my opinion, death occu	o, and due to the caus irred at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
To th within To th comp	9b. Signature and title of certifier	adel	25	9c. License number		Date signed (Month,	Day, Year)
	> Spanson	all		HO05997	3 5	17/04	7
36	0 1 1 1 1	rpleted cause of death (Item	1 1	Hos 5997 Cambria	1	7 7//	13
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			State of Maryland / Department of Health and  1- State Recistrar  Certificate of Death		2000 10400
	_			Reg. I	No. 3. Time of Death
F	Physicia	an	1. Decedent's Name (First, Middle, Last)  May Francis Mills Washington		Day Year
	/Medic				6, 2006 7:55 P M
	Examin	er			
			5. Social Security Number 6. Sex / 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs		Queen Annes  9. Birthplace (State or Foreign
	uneral rector		218-20 3282 10 M 21 F 84 Yrs. Months Days Hours Min.	(Month, Day, Yea	21 Maryland
			Usual Residence of Decedent	Dec. 1, 14	21 11/4/9/4/18
ylan	Mow E		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Mai	a-t s	Ş	MD Queen Anne's Grasonville		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
2 €	or 28	ire	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
_ <del>=</del> <u>₹</u>	23a	Funeral Director	5511-Main Street 2/638		USA
, å	lems Lems	ne	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
s affe	ro'E	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 12 No 1 □ Yes 2 12 No 5 pecify: Year or Dates:		Specify: / / /
5-0050 Colors after death with the Maryland	lural'	d b		106	B/ack Kind of Business/Industry
0.72	"na	Completed	(Specify only highest grade completed) (Give kind of work done during most of wo	orking	ŕ
filed within Hygiene.	than the M	ᇤ	Elementary/Secondary (0-12) College (1-40r 5+)  Dome Stic Work	$\geq  P_{v} $	rivate Residence
Hygi	ent, I			me (First, Middle, Maid	len Sumame)
VICILIA Z IZ ould be filed with Mental Hygiene.	c ev	To Be	EMORY Mills	rie M	iller
should nd Mer	mar	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ri	1	y or Town, State, Zip Code)
P P P	27 is r trat		Lee Washington 1530/ Johnstone	Lane Bru	lie MD 20721
es ta of Hei	ltem othe		20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c.	Logation - City or Town, State
rmit. Pages	ortant: if them 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at g.		1 12 Burial 2 Cremation 3 Removal from State  14 Donation 5 Other (Specify)  8 Removal from State  8 Removal from State	2106 G	rasonville, MD
Dallilli permit. Pag Department	Important: I any injury o once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  1+enry Funera	1 HOME P.	Δ
0 88	any ir		Janelle C. Henry 510 Washington	N St. COM	bridge, MD.21613
			23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	c or respiratory arrest,	Approximate Interval Between
Phy:	sician		Immediate Cause (Final disease or condition a Endometrial Cancer		Onset and Death
	edical		resulting in death)  Due to (or as a consequence of):		Tyears
Exa	miner		Sequentially list conditions.		
P	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
ecute	-tran	каш	Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
ate be ex	physician and the burial-transit	ai E	Due to (or as a consequence of).		
cate	phys the	dicai	d		
Sertifi	been signed by the attending p should be detached for use as t	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
eath cer	for u	cian	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy		Month Day Year
) §	y the	ıysi	1   Yes 2   No 9   Unknown 9   Unknown		
that	deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
w requires	ld be	d b	Hypertensian Diabetes Mellitus	1 🗆 Yes	2 No 3 Probably 4 Unknown
5 8	shou	lete		24a. Was an	24b. Were autopsy findings available
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ian: T	ificat or, pa	C	25. Was case referred to medical 26 Place of De	1 ☐ Yes 2 ☐ I ath (Check only one)	No 1 ☐ Yes 2 ☐ No
slcia	lirect	To B	examiner?	Home 5 ☐ Residence	6 KOther (Specific) 11 - 1
2 g	eral c		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how in	1,1931-100
	r: Aft	atio	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No		
Attending or death.	by th	Hic	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, Str	and Number or Rural Route Number,
tal or	ed in	Certification:	Sulaing, see (openly)	ony or rown, on	
lospi hour	uner ely fill	edical	29a. Certifier (Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Check only   Ch	e, and due to the cause	(s) and manner as stated.
DIVISION OF VITAL INCOMINS, IT.O. DOX 00/00, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medi	one) and manner stated.		
Tow	CO	-	29b. Signature and title of certifier 29c. License number	/	Date signed (Month, Day, Year)
			1 Duly D4749	2 31	10/2004
			CO Name and address of access with a small stand access of death (trans CO ) (The CO )		
			30. Name and address of person when pleted cause of death (Item 23a) (Type, Print)	21601	
	Sta	ite.	30. Name and address of person with completed cause of death (Item 23a) (Type, Print)  Jeffrey T. Denton 555 Cynwood Drive Easton, Maryland  31. Date filed (Month, Day, Year)  32. Régistrar's Signature	21601	

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1-For State Control of Pleatin and Wental Certificate of Death		g No. 200	16 1618
Physicia	ın/	Decedent's Name (First, Middle,Last)	Date of Death     Month	h Day <b>Y</b> ear	3. Time of Death
Medical Examir	ner	WADE EELIS WHITE	May 5, 200	06	0227 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Divergale	eath	4c. County of Dear	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	1Hrs 8 Date of Birt	h(MM/DD/YYYY) 9. Bi	
Director		212-64-2052 1XM 2F 40 Yrs. Months Days Hours	Min.	Forei	gn ountry) Maryland
ń	1	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d Inside City Limits
0 00 m		W 1 1 D 1 0 1 1			1 Yes 2 No
ırylanı la-f sl	Ç	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	11.
th the Ma 23a or 28 notified	al Director			U.S.A.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once,	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		White, etc.	rican Indian, Black,
rs afte ural",	含	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind	of work done	Specify: 16b. Kind of Business	White
2 hou "nati	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		TOD. KING OF BUSINESS	industry
21215-0036 suld be filed within 7 Mental Hygiene marked other than ic event, the Medica	힐	F.O.I. Specialist		F.D.A.	
5-0( ed wi tygier other	S		ame (First, Middle, M	laiden Surname)	
be fill brinked rent, i	Be		a Rose Sid	_	
D 21 hould and Me is ma	유	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number			
MD nd 2 sho alth and m 27 is		Amy E. Sanders-White - Wife   131 Westway, Apt. 7			
ore,		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	Date	20c. Location - City or	Town, State
imc Page ment tant: or ot				Suitland,	
Baltimore, permit. Pages I an Department of Hea Important: If ite	1	21. San Tre of Funeral Service Densee 22. Name and Address of Facility			•
	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia			_
Physician /Medical		failure. List only one cause on each line.	ac or respiratory arre	st, snock, or neart	Approximate Interval Between Onset and
Examiner	Ì	Immediate Cause (Final disease or condition resulting in death)  Multiple Injuries  Due to (or as a consequence of):			Death
		Sequentially list conditions b.			
	ner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
	Examiner	Colleges or injury that initiated events resulting in death) Last Due to (or as a consequence of):		-	
		d			
be exe	Medical	UNPENDED AMENDED			
760, Trate be g physical		IF FEMALE:  23c. If yes, outcome of pregnancy  23b. Was decedent pregnant in the		23d. Date of deliver	
certificant	/sician/	past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pre	gnancy	Month I	Day Year
Box 68 in death certificate at the attending ted for use as in	ysi	1 Yes 2 No 9 Unknown 9 Unknown		İ	
Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as	y Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
cords, P.C. law requires that has been signed that be deter	d by		1 Yes	2 No 3 Prof	oably 4 Unknown
rds	Completed		24a, Was ai		topsy findings available completion of cause of
ecc he lav nte hav	E C		perform	ned? death?	
ni T	ادہ	25. Was case referred to medical 26.Place of Death (Che		No 1	2 10
Vita	To B	examiner?  1 Ves 2 No Other Do Do Do Do Do Do Do Do Do Do Do Do Do	rsing Home 5 R	Residence 6 🗸 Othe	r: Scene
Division of Vital Records, P.O. ral or Attending Physician: The law requires that thers after death.  'al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach		27. Manner of Death  28a. Date of Injury (Month) Day Year)  1 Natural 5 Panding May 5 200 hrs  1 Yes 2 No.		ow injury occurred	
ion tendi eath. tor: /	atio	1 Natural 5 Pending 2 Accident Investigation May 5, 2006 May 6, 2006 May 6, 2006 May 1 Yes 2 No	Driver in mot	or vehicle accide	nt
ivisior or Attend after death Director:	ijiji	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (St or Town, Sta		ral Route Number, City
Spital sours a neural filled	Certification:	4 Homicide determined (Specify) Local Street	6504 Kenilwo	orth Ave, Riverdal	e,MD
	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	and due to the cause	(s) and manner as star	ted
To the within To the comple	Ned	and manner stated  29b. Signature and title of certifier  29c. License number			
	-	O.C.M.E.		29d Date signed (Mo. May 5, 2006	min, Day, rearj
		( activolities)			
R (11)		Number of address of person who completed cause of death (Item 23a)     Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201		
Sta	ite	31 Date filed (Month, Day, Year) Registrar's Signature			
Regist	rar	MAY 1 1 2006 Blow & Grant			

			1 - For State Registrar	te of Maryla	and / Depa <i>Cei</i>	artment o	of Health of Deat	n and M th		iene	06	16482
			Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th	Mada	3. Time of Death
	Physicia /Medic		Clara B.	Willi	n				May 13	, ^{Day} 2006	Year	8:00
	Examin		4a. Fecility Name (If not institution, give street a	nd number)		4b. City, Tov	vn, or Location	on of Death		4c. County	of Deeth	
			131 Civic Ave.			Salis					comic	)
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2	PT 4	rs. last birthday) Yrs.	If Under 1 Y Months D	ear If Unc ays Hour	der 24 Hrs. 's Min.	8. Date of Birth (Month, Day 9/22/19	Year)		lace (State or Foreign try) Land
P			Usual Residence of Decedent		a: <b>T</b>						4	ad tasks Obs. Date
nylar	a how	_	10a. State 10b. County	100.	City, Town or Lo						1	0d. Inside City Limits 1 XYes 2 □ No
Je M	8a-f	ecto	Maryland Wicomico		Salisbu					0g. Citizen of	14/5-1-0-1-0	
with t	De D	급	10e. Street and Number 131 Civic Ave.			10f. Zip Co				USA	Wilat Court	пут
eath	rs 23	era		s Decedent Ever in	U.S. 13.	Was Decedent	of Hispanic	Origin? (Spe	ecify Yes or No-		ce - Americ	an Indian,
s after d	or them	by Funeral Director	1 Never Married 2 Married 1 HY	ed Forces? Yes 2 TNo es, Give ir or Dates:		If Yes, specify 1 ☐ Yes 2【X	Cuban, Mexi	can, Puerto	Rican, etc.)	Bla Specif	ck, White, o	
3 2	furat	ed b	15. Decedent's Education	II OI Dales.	16a. Dece	dent's Usual O	ccupation			16b. Kind of B		
in 72	an 'n	Completed	(Specify only highest grade comp		(Give	kind of work a DO NOT use n	one during m	nost of worki	ng	100.11.10 0.0		
with	r than	E O	Elementary/Secondary (0-12) Col	ege (1-4or 5+)	Home	maker				Domest	ic	
2 = 2	othe	Be C	17. Father's Name (First, Middle, Last)				18. Mo	ther's Name	(First, Middle,			
nd bu	Venta rked tic e	ToE	Claude Bailey				E	dna Be	nnett			
nd 2 sho	Department of Health and Mental Hygiene. Important: or items 23e or 28e-f show Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship (Type, Prin Benny Willin/husband	nt)					Boute Number bury, M			Code)
Ges 1 al	nt of Hea If item or othe		20a. Method of Disposition 1 ■ Burial 2 ■ Cremation 3 ■ Remova		Place of Dispo cemetery, cres	natory or other	place)	5/17/		20c. Location		
mit. Pa	Departmer Importent: eny injury once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Cicensee	0.00	Cemete	ry Hollowa	ddress of Fa	eral H	lome Pro	fessior	nal As	ngs, MD ssociation
<b>a</b>	2559		Coll & xtrue	(EST)		501 Sno	W Hil.	I Rd.,	Salisb	ury, MI	2180	)4
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final	e on each line.						_		Approximate Interval Between Onset and Death
	iysician Medical		disease or condition resulting in death)	ue to (or as a cons	M RONIC	Obst	SUCTI	VE PO	elmone	Disa	000	YEARS
	caminer			40 (0) 43 4 00113	equalities of j.					J		
P	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a cons	equence of):							_
ecute	physician and s the burial-transit	Examiner	that initiated events c	ua to /or as a sono	aguagae of):							
e be ex	cian a	Ē	resulting in death, 225t	ue to (or as a cons	equence or):							
cate	physi the t	dical	d							<u> </u>		
Certifi	iding ise as	/Me	IF FEMALE: 23c. If y	es, outcome of pre	gnancy					23d Da	te of delive	rv
Jeath	d for u	Physician/M	in the past 12 months?	Live birth 2 Fregnant at time of		∃Ectopic pregr ∃ Other (s <i>pecif</i>						Day Year
	by the	hysi	9 Unknown 9	Unknown								
The law requires that the death certificate be executed	been signed by the attending p should be detached for use as	by	Part II. Other significant conditions contributing	g to death but not a	esulting in the u	nderlying caus	e given in Pa	ırt I.	5.00	pacco use con es 2 □ No		e cause of death?
v requir	been	lete							24a. Was a	n 24b	Were autor	sy findings available
The la	te has	Completed							autops perfor	y ned?	prior to con death? 1  Yes	npletion of cause of
	rtifica tor, p	Be C	25. Was case referred to medical				26. Pl	ace of Death	(Check only on	7		
ysic	direc	To	examiner? 1 Yes No Hospital	1 ☐ Inpatient 2	☐ ER/Outpatier	nt 3□ DOA	Other: 4 🗆	Nursing Hor	ne Reside	nce 6 Oth	er (Specify	9
ding P	fter th		27. Manner of Death  12Natural 5 Pending	Date of Injury (Month, Day Yeer,	28b. Time o Injury		Injury at Work?	i	28d. Describe ho	w injury occur	red	
and C	eath.	cati	2 Accident investigation		1	М	1 Yes 2					_
al or Att	s after d	Certification:	4 Homicide determined 28e	Place of Injury - A building, etc. (Spe	t home, farm, str ocify)	reet, factory, of	fice		28f. Location (St City or Town		er or Rurai	Route Number,
To the Hospital or Attanding Physician:	within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (	29a. Certifier (Check only one) Certifying Physician: 2 Medical Examiner: Or an	To the best of my in the basis of examined manner stated.	nowledge, deat ination and/or in	h occurred at the vestigation, in	ne time, date my opinion, d	and place, a death occurre	and due to the caed at the time, d	ause(s) and ma ate and place,	anner as sta and due to	ited. the cause(s)
o the	Mithin Fo the	Me	29b. Signature and title of certifier	1		29c. Li	cense numbe	er er	2	9d. Date signe	d (Month, L	Dey, Year)
-	VIII.		1 Thefp- Text			D3	36576	S		5/15/	66	
	AVE		30. Name and address of person who complete	d cause of death (I	tem 23a) (Type,	Print)				1-1	~	
<u>V</u>	) (		RONALD P. TRANS		560	RIVE	2510	E De	SAL	SBUR	> u	2
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	1 4						

ORIGINAL

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) (1)

			For Stata Registrar	State of Maryland		tificate of l		F	Reg. No.	Ub	1646
	Physici		1. Decedent's Name (First, Middle, Last)  Irene Martha	Zeidman				2. Date of Dea		Year	3. Time of Death 12:20 A _M
	/Medio Examir		4a. Facility Name (If not institution, give s Suburban Hospita	street and number)		4b. City, Town, or Bethes	Location of Death		4c. Count Mor	y of Death	
	Funeral Director		5. Social Security Number 6. Sex 087–12–3578		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Mayont 5 Day	1/92/1	9. Birth	place (State or Foreign Wy) YOTK
	Maryland -f ehow	tor	Usual Residence of Decedent		Town or Lo	cation L1e					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28a	Funeral Director	10e. Street and Number 1801 E. Jeffers	on St.		10f. Zip Code 20	852		10g. Citizen of	Whal Cou	
036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel', or items 23a or 28a-f show mary injuryate their traumatic event, the Modical Erain or must be notified at once.	Ď	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes Zo No If Yes, Give ² Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2€ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce Americk, White,	
Maryland 21215-0036	within 72 ho ene. than "natur te Medical.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life. l	dent's Usual Occupa kind of work done d DO NOT use retired,	uring most of work	ing	16b. Kind of B		ompany
land 2	uld be tited Mental Hygi irked other itic event, I	To Be C	17. Father's Name (First, Middle, Last) Abraham Ka	lik	Sec	retary	18. Mother's Name Anna	Guterma	Maiden Sumar		ompany
, Mar	and 2 sho saith and ! n 27 is ma		19a. Informant's Name/Relationship (Ty) Eric Zeidman / so:	n		g Address <i>(Street a</i> Maple Ave	nd Number or Rura ••• Chevy	Chase,	MdV.°′ ⁷ 2'07	3 <b>13</b> 9, Zip	Code)
Baltimore,	thent of He tant: If iten		20a. Method of Disposition 1 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	emoval from State Bet	h Mos	sition (Name of natory or other place es Cem.	May	12, 2006		rming	dale, NY
Ba	permit Depar Impor eny In		21. Signature of Funeral Service license	12rder	2	54 Carrol	1 St., N	V, Washi	ngton,		eral Home 0012
	Physician /Medical		23a. Part1. Énter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. e cause on each line.  Due lo (or as a conseque	Meta	er the mode of dying	s, such as cardiac d	or respiratory arr	est,		Approximate Interval Between Onset and Death
68760,	tificate be executed by g physicien and as the burial-transit	edical Examiner	Sequentially list conditions, and the cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque							
	The faw requires that the death certificat lie has been signed by the attending phy bage 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 OX No 9 □ Unknown	Sc. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 🗌	Ectopic pregnancy Other (specify)			23d. Dai Mo	te of delive	ory Day Year
ords, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions con  Renal Failure		ing in the un	derlying cause give	n in Part I.				ne cause of death?
al Records,		Completed						24a. Was a autops perform	ned?		psy findings available inpletion of cause of
Division of Vital	Attending Physicien: r death. ector: After this certitics by the funeral director.	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  He  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		NOutpatient 8b. Time of Injury	3 □ DOA Other 28c. Injury Work	+ □ Ivui sirig ⊓or		ence 6 Oth		)
Divis		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, elc. (Specify)	e, farm, stre	et, factory, office		28f. Location (St. City or Town	reet and Numb n, State)	er or Rurai	Route Number,
	To the Hospital or within 24 hours after to the Funeral Dir completely tilled in	Aedical	one)	ician: To the best of my knowle er: On the basis of examination and manner stated.	edge, death n and/or inv	estigation, in my opi	nion, death occurre	ed at the time, da	ate and place, a	and due to	the cause(s)
•	Con Con	M	29b. Signature and title of certifier	J. WILL S	10	D 0063		25	9d. Date signed May 9	, 200	Jay, Year) 16
			30. Name and address of person who cor	D , 6121 MOnt	cose F	d., Rocky	ille, MD	20852			
34	Sta Registr	_	31. Date filed (Month, Day, Year) WAY 10 20	32. Registrar's Signatur	E A	autes					

Zeidman, Erene 519106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] [ ] 16484 Certificate of Death 2 Date of Death 3 Time of Death . Decedent's Name (First, Middle, Last) **Physician** 0825 M Appel 2006 MAS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Belair Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖫 F 212-03-5608 86 Yrs. October 13, 1919 Director MAryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or Itams 23a or 28a-f show Madical Examiner must be notified at 1 ☐ Yes 2 No Be Completed by Funeral Director Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 1614 Four Georges Court A3 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 10 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 Is marked oth any lojury or other traumatic svent ans. William S. Schaffer Anna Eberwein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1614 Four Georges Court A4, Dundalk, Md. 21222 Pat Cropper Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 27, TyD Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Dundalk, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part | Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Klean **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to unmediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 ☐ Yes 2 ② No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 22No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Ø No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending death. 1 Tes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Director within 24 hours a completely 0

Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE ISCHARMS

MCMC500 MPPER CHESAPEAKE OF GEORGE ISCHARMS 31. Date filed (Month, Day, Year) MAY 2 5 2006

D. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0063220

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 1:00 A M NES 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FRANKFORD NURSING HOME MORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 12M 2□F 212-34-Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-4 ehrem any injury or other traumatic event, the Medical Experiment. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Funeral Director MARYLAND 10e. Street and Number 10g. Otizen of What Country? 500 USA 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: BLACK Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) +#GRADE IMPROVEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) RSON 2 TONE HARLES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RNON SON (BROTHER) BALTI HORE MD 2/2/5 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State LANSDOWNE * 4 □ Donation 5 □ Other (Specify) ZION 22. Name and Address of Facility 21. Signature of Funeral Service Licensee BROWN mich 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical of delivery Day Year bute to the cause of death? 3 ☐ Probably 4 Donknown Vere autopsy findings available vior to completion of cause of leath? ☐ Yes 2☐ No Certification: To r (Specify) be within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	il death 3 □Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions o	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacco	ouse contribute to the cause of deat 2 No 3 Probably 4 Dunki
				24a. Was an autopsy performed?	
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3□ [	OOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Specify)
27. Manner of Death  Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia		ory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number te)
	ysician: To the best of my kno niner: On the basis of examina and manner stated.				(s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier		2	9c. License number 057727	5	ate signed (Month, Day, Year)
30. Name and address of person who	completed cause of death (Iter	an 23a) (Type, Print)	lace De	walk "	mD21222
31. Date filed (Month, Gay, Year)	32. Registrar's Signa	ature			

State Registrar

Medical

31. Date filed Month, 2ay, 3 ear 006

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,	Physici	an	Decedent's Name (First, Midd	fle, Last)								<ol><li>Date of De Month</li></ol>	ath Day	Yea		. Time of Deat	h
	/Medic		Joseph	Mich				Ansel	mi			May		2006		8:55 F	M
	Examin	ner	4a. Facility Name (If not institution	on, give str	eet and numb	er)		4b. City.	Town, or	Location of	Death		4c.	County of D	eath		
17	ş.	\$/1.	6412 Orchard					If I lade		thicu				Anne A			_
	Funeral		5. Social Security Number 217–12–3496	6. Sex 1 🔀 N	/ 2□ F		iast birthday) Yrs.	Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da	y, Year)	9. 1	Country)	(State or Fore	əign
	Director		Usual Residence of Decedent			81						Mar.17	1927		MD		_
200	A H		10a. State 10b. Count	у		10c. Ci	ty. Town or Lo	ocation							10d. I	nside City Lin	nits
Na Sa	- 3	ŏ	MD Anne	Arund	le1	I	inthic	um							1	1 ☐ Yes 2 🔀	No
4	288	Director	10e. Street and Number						Code				10g. Citi:	en of What	Country?		_
with	38 0	ō	6412 Orchard R	oad					21090	1			U.S	٨			
the at	ital Hygiene.  do other then "natural", or iteme 23a or 28a-f ehow event, it e Medical Ezardicar must be notified at	Funeral	11. Marital Status		. Was Decede		.S. 13.				in? (Spec	cify Yes or No Rican, etc.)		4. Race - A		ndian,	
C	1	교	1 Never Married 2 Ma	rried	Armed Force 1 ☐ Yes 2	ss? █No					Puerto P	Rican, etc.)		Black, W			
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N 2	reig/	Con	8				Fact	ory V	Vorke					Domin	o Su	gar	
Maryland	al H ven	Be	17. Father's Name (First, Middle	, Last)						18. Mother	's Name	(First, Middle,	Maiden	Sumame)			
	Ment	2	Michael Ansel	mi						Jose	phin	e Mont	i				
<u>a</u>	and ls ma		19a. Informant's Name/Relation		, Print)		19b. Maili	ng Addres	s (Street a	nd Number	r or Aural	Route Numbe	er, City or	Town, State	ə, Zip Coa	fe)	
2 6	n 27		Mrs.Robin Kagl	e /	Daught						Lint	hicum,					
	of Her		20a. Method of Disposition  1 XBurial 2 ☐ Cremation	3 □Rer	moval from Sta	20b. i	Place of Dispo cemetery, crei	nsition (Na. matory or c	me of other place	) M	lay 2	7	20c. Lo	cation - City	or Town,	State	
	ant: I		4 Donation 5 Other			G1	en Hav			rk 📙	2006			Burni		_	
baltimore,	Department of Health and Mental Hygiene. Important: or iteme 23a or 28a-1 ehow any Injury or other traumatic event, it a Medical Exandrat must be notified at 2009.		21. Signature of Funeral Service	Licensee			22	2. Name a	nd Addres	s of Facility	Sin	gleton	Fune	eral H	lome,	P.A.	
ם פ	20 = 20		Month	· Kon	nen	Mol	357 1	Seco	ond A	venue	SW	Glen B	urnie	e, MD	2106	1	
E	hysician physician and the parial-transit the parial-transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	<ul><li>a.</li><li>b.</li><li>c.</li><li>d.</li></ul>	Due to (or	as a consec as a consec as a consec	uence of):	i.	1161								
The law requires that the death certificate be executed	been signed by the attending phy	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	230	e. If yes, outcon 1 □ Live birth 4 □ Pregnan 9 □ Unknow	n 2 ∏ Feta tattime of c	death 3	∃Ectopic p ∃ Other (sp					2	3d. Date of o	delivery Day	Year	
CUS, r	n signed uld be de	by	Part II. Other significant condi	ions contr	ibuting to deat	h but not res	ulting in the u	nderlying o	ause give	n in Part I.		_	obacco u: Yes 2		to the ca Probably	use of death?	
DIVISION OF VICAL MECOFUS,	is certificete hes bedirector, page 2 sho	Completed	1							<u> </u>				24b. Were prior to death	to complet	indings availation of cause	ble
VISION OF VICAL	certificete rector, pag	Be	25. Was case referred to medic examiner?								of Death	Check only o	1000				
7 × ×	this ce al dire	ို	1 ☐ Yes 2 No	Hos	spital: 1 🗌 Inp	atient 2	ER/Outpatier	nt 3 🗆 D	Othe Othe	r: 4 🗆 Nur:	sing Hom	e 5 Resid	dence 6	Other (S)	ресіғу)		
2 2	fter t		27. Manner of Death 1 ☑Natural 5 ☐ Pend	ina	28a. Date of I (Month,	njury Day Year)	28b. Time o	f	28c. Injury Work	at ?	2	8d. Describe f	now injury	occurred			
	or: Al	atic	2 Accident inves	tigation				М	1 🗆 Y	′es 2□N	lo						
Plor Att	s after death.  It Director: After ad in by the funer	Certification:	3 ☐ Suicide 6 ☐ Coule 4 ☐ Homicide deter	mined	28e. Place of building	Injury - At h , etc. (Special		reet, factor	y, office		2	8f. Location (5 City or Tox	Street and vn, State)	Number or	Rural Roi	ute Number,	
L To the Hospital	within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	edicai	29a. Certifier 1 Certify (Check only one)	ing Physic I Examine	cien: To the be r: On the basi and manner	s of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	e, date and inion, death	place, ai	nd due to the d at the time,	cause(s) date and	and manner place, and d	as stated lue to the	cause(s)	
Tot	within 2 To the complet	×	29b. Signature and title of certif	91				29	c. License	number			29d. Date	signed (Mo	nth, Day,	Year)	
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	12		30. Name and address of person	n who com	pleted cause	of death (Iter	п 23а) (Туре,	Print)			-			1			
	10		227 St. Paul	Plac		Bouti	more	M	0	2170	2						
1	Sta	ite	31. Date filed (Month, Day, Yea	r)		istrar's Signa	ature	0 40									
	Registr	rar	MAY 2	5 200	5	GERRIO I	A La	Mary .	,								

			For State Registrar	State of Ma		-		f Health a of Death		-	giene 2 Reg. No.	006	1648
186	Physici /Medi		1. Decedent's Name (First, Middle, Las Elsie Leona Abbot	•						Date of De Month	Day	2006	3. Time of Death
	Examir		4a. Facility Name (If not institution, give Good Samani tal	n Hospit	'al		Balt	n, or Location of	of Death	7	4c. Cou	nty of Death	
×6	Funeral Director			ox □M X√F 7. Age	(In yrs. last birti		If Under 1 Ye Months Da		Min.	Date of Bir (Month, Da	th ay, Year) 1912	Cour	olace (State or Foreign eryland
	ith the Maryland or 28a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland		10c. City, Town		tion				-	1	10d. Inside City Limits 1 ▼ Yes 2 □ No
	th with th	al Dire	10e. Street and Number 4124 Mary Avenue				10f. Zip Cod 212				U.S.A.	of What Cour	itry?
900	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or itema 23s or 28s-1 show surmatic event, the Medical Exportment and be multified at	d by Funeral	11. Marital Status  t ☐ Never Married 2 ☐ Married  3 ∰ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:		If Ye	es, specify C	of Hispanic Ori Luban, Mexican No Specify:	i, Puerto Rio	y Yes or No an, etc.)	E	Race - Americ Black, White, acity: Whi	etc.
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Maryland ;	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the M	To Be C	17. Father's Name (First, Middle, Last) Oliver Cox				-			First, Middle, Edenfi	Maiden Surr Le1d	name)	
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Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr onca.		20a. Method of Disposition  1	)	20b. Place of cemetery Meadow	ridge 22. N	e Mem.	Pk.	yMille	-06 er-Dip	Elkrid pel Fu	neral	Home, Inc.
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α_	w requires that been signed b should be deta	þ	Part II. Other significant conditions or	ontnbuting to death bu	t not resulting in	the unde	orlying cause	given in Part I.					ne cause of death?
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Division of Vit	ding Phys h. After this funeral di	cation: To Be	27. Manner of Death  1 ☑Natural 5 ☐ Pending  2 ☐ Accident investigation			me of jury	28c. Ir	O++	rsing Home	-	one)  dence 6 0  now injury occ		t)
DIVI	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	building, etc.	(Specify)		. ,,			City or Tov	vn, State)		i Route Number,
	To the Hospital within 24 hours of the Funeral completely filled	Medical	(Check only 2 Medical Exam	rsician: To the best of iner: On the basis of and manner stat	ed.	or invest	tigation, in m	y opinion, deat	th occurred	at the time,	date and plac	e, and due to	the cause(s)
	To with	~	29b. Signature and title of certifier  Tenance		enti	10	DC	onse number 20 58	57	0	May	ned (Month, I	2006 2006
	6		30. Name and address of person who of TENNANCE L. Bo	ompleted cause of de	ath (Item 23a) ( 5601 L	och	nt) Bai	en Blu	id, L	Balti	more,	MO	21239
	Sta Registi	100	31. Date filed (Month, Day, Year)  MAY 2 5	32. Regular	's Signature	15	ale						

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Maryland		tificate of			Reg. No.	06	5433
	Dhomini		1. Decedent's Name (First, Middle, Last)		_	- /-		2. Date of Dea			Time of Death
met.	Physici /Medi		Geraldine		6	aker		Month 5	212	006 G	:05 PM
	Examir	1er	4a Facility Name (If not institution, give st				4b. City, Town, or I	ocation of Death	4c. County	of Death	
			5. Social Security Number 6. Sex	· Care Cen:		If Under 1 Year	Baltim			0.0:41	(O
	Funeral Director		220-/2.9604	w 201 F 72	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day		9. Birthplace (Country)	(State or Foreign
	yland		10a. State 10b. County	10c. City	, Town or Loc	ation					side City Limits
	Sa-f s	ctor	M(I)		Balt	more				1	Yes 2□No
	it to a	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Country?	
	ier death with the Marylar Items 23a or 28s-f show Iner must be notified at	erai	3512 Rhom	2. Was Decedent Ever in U,S	10.14	21	707		U.	5.H	dia=
21215-0020	72 hours after death with the Maryland naturel', or items 23a or 28e-f show dical Exacilher must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	. was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates:	lf	Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerti Specify:	pecity Yes of No- o Rican, etc.)	Specify	e - American Ind ck, White, etc. CB/aC	16
5-0	72 h	Completed	15. Decedent's Educa (Specify only highest grade	tion completed)	16a. Decede	ent's Usual Occup	ation during most of word	king	16b. Kind of B	usiness/Industry	
121	within ene.	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D		•		2		
	Hygie ther i		17. Father's Name (First, Middle, Last)	5+		leache	18. Mother's Nan	ne (First, Middle,		neve City	Ż .
an	Mantal Mantal arked o	To Be	Wellington	Rideout				le Boi		,	
Maryland	shou and M s mer umet	-	19a. Informant's Name/Relationship (Type		19b. Mailing	Address (Street	and Number or Ru			State, Zip Code	)
	and 2 saith a 27 is		Thomas Baker / h	usband	351	2 Rhon	1 Rd &	Baltim	ore m	0 212	207
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei	20b. Pla	ace of Dispos metery, crem	ition (Name of atory or other plac		Date		City or Town, S	
Ë	ment ment: I		4 Donation Other (Specify)		Buty	5 ceme	etery s	5/27/06	Arbut	us, M	$\mathcal{D}$
Baltimore,	permit Depert Import any Inj ence.		21. Signature of Funéral Service tromsee	Green	87	Variables	ss Cfácilisme	ere fu Rand	neral	Servit	
ON.			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. cause on each line.	Do not ente	the mode of dyin	g, such as cardiac	or respiratory arr		Appr	oximate val Between
	Physician		Immediate Course (Final	~	3					Onse	et and Death
-AC	/Medical Examiner	G _E	Immediate Cause (Final disease or condition resulting in death) a.	Demen	tia					Ye	ars
		er		Due to (or	as a consequ	ence of):					
V	outed ansit	Examiner	Sequentially liet conditions	Due to (or	as a consequ	ence of):					
Ó,	e exection and and and and and and and and and an	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	= 55 15 (5)							
68760,	rificeta be executed ng physician and es tha bunal-transit	edicai	that initiated events resulting in death) Last	Due to (or a	as a consequ	ence of):					
		~	d								
Bo	attend for us	clan									
P.O. Box	The law requiras that tha death cer ate has been signed by the attendir page 2 should be detached for use	Physician/	Part II. Other significant conditions contri	buting to death but not result	ting in the und	derlying cause give	en in Part I.				ause of death?
Д.	that ned b	by Pt	Hypertension					1□Y	es 2⊡ No	3 Probably	4 Winknown
Division of Vital Records,	quiras n sign	g p	.,					24a. Was a		24b. Were au	topsy findings
000	s bee	plet			-			perfor	ned?	available completion of death?	on of cause
~	The It	Completed						104	s 22No	1 ☐ Yes	2× No
ita	lan: irtifica ctor, p	Bec	25. Was case referred to medical examiner?				26. Place of Deal	h (Check only on	e)		
7	Physician: rthis cartific rel diractor,	2	1 □ Yes 2 ⊉¶Yo Hos		R/Outpatient		#E⊒Nursing Ho	ome 5 🗆 Reside	nce 6 □Othe	er (Specify)	
Ĕ	Ing P	ü		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe ho	w injury occurr	ed	
<u>s</u>	Attending in death. Sector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom			Yes 2□No	28f. Location (St		D / D	h A( h
<u>≥</u>	aftar Direct	Certification:	4 Homicide determined	building, etc. (Specify)	ic, iaiiii, stiet	n, lactory, office		City or Town	, State)	er or hurar hour	e Number,
	spita hours neral y fillat	aic	29a. Certifier Certifying Physic	an: To the best of my knowl	edge, death o	occurred at the tim	ne, date and place,	and due to the ca	tuse(s) and ma	nner as stated.	
	To the Hospital or Attending Physician: The law within 24 hours aftar death. Within 24 buneral Director: After this cartificate has completely fillad in by the funeral director, pege 2	edicai	(Check only 2 Medical Examine one)	On the basis of examination and manner stated.	n and/or inve	stigation, in my op	pinion, death occur	red at the time, da	ate and place, a	and due to the ca	ause(s)
	To the To the Com.	Σ	29b. Signature and title of certifier	0		29c. License			-	(Month, Day, Y	
			Joron Blace	& MD		D006	11199		May	,221	2006
	12		30. Name and address of person who comp	pleted cause of death (Item 2	23a) (Type, P	rint)	51199 St, S	-/ 0			00101
			Jason Jack 31. Date filed (Month, Day, Year)	32. Registrar's Signatu	01146	harks	57,5	ut le	07, W	uson 1	742/204
	Sta Registra	_	MAY 2 5 200		1 A	sel.					-

06-03390 Mark Daniel Begley

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Mark Damiel Begley  4a Facility Name (if not institution, give street and number)  6326 Beechfield Avenue  5 Social Security Number  212-78-2875  11 Mart 2 F  10 Social Security Number  212-78-2875  11 Mart 2 F  10 Social Security Number  212-78-2875  12 May 2 F  10 Social Security Number  212-78-2875  13 Mart 2 F  10 Social Security Number  212-78-2875  14 Mart 2 F  15 Social Security Number  212-78-2875  15 Social Security Number  212-78-2875  16 Sex  17 Age (in yrs. last birthday)  212-78-2875  17 Age (in yrs. last birthday)  212-78-2875  18 Months Days Hours Mn. 02/22/1969  10 Street and Number  6326 Beechfield Ave.  10 Street and Number  6326 Beechfield Ave.  11 Martal Status  1 Never Married 2 XMarried  1 Never Married 2 XMarried  1 Never Married 2 XMarried  1 Never Married 2 XMarried  1 Never Married 2 XMarried  1 Never Married 2 XMarried  1 Never Married 2 XMarried  1 Never Married 2 XMarried  1 Never Married 2 XMarried  1 Never Married 2 XMarried  1 Never Married 2 XMarried  1 Never Married 2 XMarried  1 Never Married 2 XMarried  1 Never Married 2 XMarried  1 Never Married 2 XMarried  1 Never Married 2 XMarried  1 Never Married 1 Number No Specify:  1 Specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No Specify:  1 Specify Cuban, Mexican, Puerto Rican, etc.)  2 No Specify:  3 Widowed 4 Divorced If Yes, Sieve Year  1 Steamfitter  1 Service  1 Service  1 Service  1 Service  1 Service  1 Service  1 Service  2 Service  2 Service  3 Service  3 Service  4 Steamfitter  1 Service  2 Service  2 Service  3 Service  4 Service  4 Service  5 Service  5 Service  5 Service  4 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  5 Service  6 Seed Seechfield Ave., Elkridge, MD  6 Service  6 Service  6 Service  6 Service  6 S	d  YY) 9. Birthplace (State or Foreign Country) MD  10d. Inside City Limits 1 Yes 2 X No  What Country?  USA  ce - American Indian, Black, lite, etc.  White  Business/Industry  ce Mechanical, IN  ne)  own, State, Zip Code)  21075
## Funeral Director    Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral Director   Funeral D	y of Death d  YY) 9. Birthplace (State or Foreign Country) MD  10d. Inside City Limits 1 Yes 2 X No  What Country?  USA  ce - American Indian, Black, lite, etc.  White  Business/Industry  Ce Mechanical, IN  ne)  own, State, Zip Code)  21075
Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Residence of Decedent  Funeral Director  Funeral Residence of Decedent  Funeral Director  Funeral Residence of Decedent  Funeral Director  Funeral Residence of Decedent  Funeral Director  Funeral Residence of Decedent  Funeral Director  Funeral Residence of Decedent  Funeral Director  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence of Decedent  Funeral Residence	d  YY) 9. Birthplace (State or Foreign Country) MD  10d. Inside City Limits 1 Yes 2 X No  What Country?  USA  ce - American Indian, Black, lite, etc.  White  Business/Industry  ce Mechanical, IN  ne)  own, State, Zip Code)  21075
Director    212-78-2875   1½ M 2   F   37   7   7   8   Months   Days   Hours   Min.   02/22/1969	Foreign Country) MD  10d. Inside City Limits 1  Yes 2 X No  What Country?  USA  ce - American Indian, Black, lite, etc.  White  Business/Industry  Ce Mechanical, IN  ne)  own, State, Zip Code)  21075
Usual Residence of Decedent    Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10a. State   10b. County   10b. City   10b. City, Town or Location   10a. State   10b. County   10b. City, Town or Location   10a. State   10b. County   10b. City, Town or Location   10a. State   10b. County   10b. City, Town or Location   10a. State   10b. County   10b. City, Town or Location   10a. State   10b. County   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b. City, Town or Location   10b.	Ind. Inside City Limits  1 Yes 2 X No  What Country?  USA  Ce - American Indian, Black, lite, etc.  White  Business/Industry  Ce Mechanical, INdian  Down, State, Zip Code)  21075
10a. State   10b. County   10c. City, Town or Location   10f. Zip Code   10g. Citizen of V   10e. Street and Number   10f. Zip Code   21075   10e. Street and Number   6326 Beechfield Ave.   21075   11. Marital Status   1. Mover Married   2 Married   1. Mover Married   2 Married   1. Mover Married   2 Married   1. Mover Married   2 Married   1. Yes   2 Mover Married   2 Married   1. Yes   2 Mover Married   2 Married   1. Yes   2 Mover Married   2 Married   1. Yes   2 Mover Married   2 Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes   2 Mover Married   1. Yes	Nhat Country?  USA  Ce- American Indian, Black, lite, etc.  White  Business/Industry  Ce Mechanical, IN  ne)  Dwn, State, Zip Code)  21075
MD Howard Elkridge    MD Howard Elkridge   10f. Zip Code   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Citizen of V   10g. Ci	Nhat Country?  USA  Ce- American Indian, Black, lite, etc.  White  Business/Industry  Ce Mechanical, IN  ne)  Dwn, State, Zip Code)  21075
6326 Beechfield Ave.  21075  11. Marital Status 1 Never Married 2 XMarried 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes 2 X No specify: 3 Widowed 4 Divorced in Yes, Give Year 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)  3 Informant's Name (First, Middle, Last) John Begley  17. Father's Name (First, Middle, Last) John Begley  18. Mother's Name (First, Middle, Maiden Suman Margaret Stewart  19. Margaret Stewart  19. Margaret Stewart  19. Margaret Stewart  20. Place of Disposition (Name of cemetery, crematory or other place)  19. Margaret Stewart  20. Place of Disposition (Name of cemetery, crematory or other place)  10. Margaret Stewart  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  21. Signature of Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Fun	What Country?  USA  ce - American Indian, Black, white  Business/industry  Ce Mechanical, IN  ne)  own, State, Zip Code)  21075
6326 Beechfield Ave.  21075  11. Marital Status 1 Never Married 2 XMarried 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes 2 X No specify: 3 Widowed 4 Divorced in Yes, Give Year 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)  3 Informant's Name (First, Middle, Last) John Begley  17. Father's Name (First, Middle, Last) John Begley  18. Mother's Name (First, Middle, Maiden Suman Margaret Stewart  19. Margaret Stewart  19. Margaret Stewart  19. Margaret Stewart  20. Place of Disposition (Name of cemetery, crematory or other place)  19. Margaret Stewart  20. Place of Disposition (Name of cemetery, crematory or other place)  10. Margaret Stewart  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  20. Place of Disposition (Name of cemetery, crematory or other place)  21. Signature of Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Functional Fun	USA  ce- American Indian, Black, lite, etc.  White  Business/Industry  Ce Mechanical, IN  ne)  own, State, Zip Code)  21075
20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metro Crematory 05/24/06 Catons  21. Signature of Funeral Service Licensee  MO1378  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metro Crematory 05/24/06 Catons  Address of Facility Funeral Home at M. T250 Washington Blvd., Elkridge.	ce- American Indian, Black, lite, etc.  White Business/Industry  Ce Mechanical, IN  ne)  own, State, Zip Code)  21075
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20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metro Crematory 05/24/06 Catons  21. Signature of Funeral Service Licensee  MO1378  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metro Crematory 05/24/06 Catons  27. Name and Address of Facility Funeral Home at M. Adultiman Funeral Home at M. 7250 Washington Blvd., Elkridge.	own, State, Zip Code)
20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metro Crematory 05/24/06 Catons  21. Separative of Funeral Service Licensee  MO1378  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metro Crematory 05/24/06 Catons  21. Separative of Funeral Service Licensee  MO1378  7250 Washington Blvd., Elkridge.	21075
20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metro Crematory 05/24/06 Catons  21. Signature of Funeral Service Licensee  MO1378  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metro Crematory 05/24/06 Catons  27. Name and Address of Facility Funeral Home at M. Adultiman Funeral Home at M. 7250 Washington Blvd., Elkridge.	21075
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Pior 1/250 Washington Blvd., Elkridge.	
Physician 23a. Part I. Enter the disease of conscitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or his	MD 21075
lalidie. List only one cause of each line.	neart Approximate Interval Between Onset and
mmediate Cause (Final disease a. Cocaine and heroin intoxication	Death
or condition resulting in death)  Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	<del></del>
if any, leading to immediate cause Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
events resulting in death) Last Due to (or as a consequence of):	
d.    AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED       AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED     AMENDED	
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O a graph of the contributions are contributing to death but not resulting in the underlying cause given in Part 1.  259. Did tobacco use contributions are contributions to death but not resulting in the underlying cause given in Part 1.  259. Did tobacco use contributions are contributions to death but not resulting in the underlying cause given in Part 1.	Probably 4 V Unknown
24a. Was an autopsy performed? 1 ✓ yes 2 No  25. Was case referred to medical examiner? 1 ✓ yes 2 No  25. Was case referred to medical examiner? 1 ✓ yes 2 No  26. Place of Death (Check only one)  27. Manner of Death 28. Date of Injury 28c. Injury at Work? 28d. Describe how injury occur	. Were autopsy findings available
autopsy performed?	prior to completion of cause of death?
Description of Death (Check only one)  25. Was case referred to medical examiner?  Hespital: □ 1 ✓ Yes 2 □ No □ 25. Was case referred to medical examiner?  Hespital: □ 1 ✓ Yes 2 □ No □ 25. Was case referred to medical examiner?	1 Yes 2 No
So via case referred to medical examiner?  1 Ves 2 No    No   Ves 2 No   Impatient 2 ER/Outpatient 3 DOA   Other   Nursing Home 5 Residence 6   Other   Nursing Home 5 Residence 6   Other   Nursing Home 5 Residence 6   Other   Nursing Home 5   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Oth	✓ Other: Scene
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Solution 29b. Signature and title of certifier 29c. License number 29d. Date sign	ned (Month, Day, Year)
(ing (ing) O.C.M.E. May 19, 2	006
30. Name and address of person who completed cause of death (Item 23a)	
Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar MAY 2. 5. 2006	

			1 - For Stata Registrar	State of Maryla	and / Depa <i>Ce</i> a	artment of rtificate o	Health and f Death	Mental F	lygie Reg	41109 100	06	5	,90
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of _ Month	Death		Year	3. Time of	Death
	/Medi	cal	Joseph Georgia. Facility Name (If not institution, give str.			45 ON T		May	23,	2006		8:13	$P^{M}$
- A	Examir	ner	Anne Arundel Medica				or Location of De Dolis	eath		4c. County		ındel	
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	and tand		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ecation					1	0d. Inside Ci	tv Limits
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	th the or 284	Director	10e. Street and Number			10f. Zip Code			10g.	Citizen of V	Vhat Coun	try?	
	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show the Medical Exarti et must be notitied at		1329 Cape Saint Cl				21409			U	SA		
	ter de	by Funeral	11. Marital Status 12.	. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of f Yes, specify Cu	Hispanic Origin? Iban, Mexican, Pu	(Specify Yes or erto Rican, etc.)	No-		e - Americ k, White,	an Indian, etc.	
980	urs af	by	3 Widowed 4 Divorced	1 Armed Forces?  1 Yes 2 No.41  If Yes, Give 41  Year or Dates: 50.	-46 -52	1□Yes 2XN	o Specify:			Specify	:	hite	
Maryland 21215-0036	72 ho	Completed	15. Decedent's Educal	tion	16a. Dece	dent's Usual Occi	upation e during most of v	mrkina	168	o. Kind of Bu	siness/Inc	lustry	
2	within ane. then	Idm	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retir	red)	.orming	Δ	11tomo	tivo	Repair	<b>-</b>
0	filed Hygie other		17. Father's Name (First, Middle, Last)		Aut	o Mecha		ame (First, Midd				кераті	-
au	Aental rked o	To Be	Thomas Butera					mella V			5)		
ary	2 should and Men is marke sumatic		19a. Informant's Name/Relationship (Type	· ·	19b. Mailir	ng Address (Stree	et and Number or				State, Zip	Code)	
	and and mealth m 27 her tra		Genevieve C. Butera	The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon	1329	Cape Sa.	int Clai	re Road	Ann	apolis	. MO	21409	)
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if them 27 is marked other than "natural; or Items 25a or 28a-f show any injury or other traumatic event, the Maritral Examt sermual be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Rem	noval from State	cemetery, cren	sition (Name of natory or other pl	ace)	Date	200	Location -	City or To	wn, State	
Ħ	uit. Pa artmer ortent injury		4 Donation 5 Other (Specify)  21. Signature Funeral Service Ucensee	Me	etro Cre	ematory,	Inc. 5/	25/06	В	altimo	ore,	MD	
Ba	permit. Departr Importa any inji		Lolwigh from		22	299 Fred	ress of Facility (derick Ro	rematic pad Ral	n S tim	ociety ore	7 of 1	MD, In	1C .
i a	7 59		Edward A. Greso  23a. Part 1. Enter the disease or complicat shock, or heart failure. List only one	tions that caused the de	eath. Do not enle	er the mode of dy	ing, such as cardi	ac or respiratory	arrest,	ore, r		Approximate	)
	hysician		Immediate Cause (Final disease or condition		011	utt. mai	Ca.					Onset and D	
212.7	/Medical Examiner		resulting in death)	Cavdiac Due to (or as a conso Myo Cav	equence of):	ginione	( )					0	
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o,	exec en and rial-tra	Exa	that initiated events c resulting in death) Last	Due to (or as a conse	equence of):	, record	ic unst	<i>a</i> 5 ( .				co year	12
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×	ding p		IF FEMALE:	If you system of pro-									
Š .	attending I	hysician/Me	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	etal death 3	Ectopic pregnand Other (specify)	су			23d. Date Mon			ear
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'n	requires inat the de een signed by the a rould be detached to	by P	Part II. Other significant conditions contrib	outing to death but not re	esulting in the un	iderlying cause g	iven in Part I.	23e. Dio	tobaco	o use contri	bute to the	cause of de	ath?
Records	nbeu Dinot	ted						1	] Yes	2 □ No :	roba	bly 4 ∏Ur	nknown
Sec	a tas	ompleted						24a. Wa aut	opsy	pr	ior to com	sy findings a	vailable use of
_ F	certificate harector, page	S	OS IMPO TO THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE					1 Yes	formed 2		eath? Yes 2	2□ No	
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	After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	4 🗀 Nursing	Home 5 Res					
SIO	r deeth.	catlo	2 Accident investigation	(, 22)	Injury		Yes 2 No						
= 1	after d	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office		28f. Location City or To	(Street own, Sta	and Number ate)	or Rural	Route Numbe	er,
	ours a cours a filled		29a. Certifier 15 Certifying Physici.	an: To the best of my kr	nowledge death	occurred at the 1	mo data and also						
J. Leginooti ett of	within 24 hours after deet To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examiner: one)	On the basis of examinand manner stated.	nation and/or inv	estigation, in my	opinion, death occ	urred at the time	, dale a	(s) and man ind place, ar	ner as sta id due to t	ted. he cause(s)	
10.1	within To #	ž	29b. Signature and title of certifier			29c. Licen				Date signed			
)			Barbara L.B.	ean		D36	1497		Mo	4 21	+ 20	06	
	6		30. Name and address of person who comp	leted cause of death (Ite	em 23a) (Type, F	Print)	1497 Jeclical	0 (	/	^		1.	
7	Stat	0	31. Date filed (Month, Day, Year)	2. SUIT	DOC, 12	00%, M	rech cal	Paule	Jay	1+11-	apo	115 Mi	>21401
	Registra		MAY 2 5 2006	A December of the second	H Los	de							

State of Maryland / Department of Health and Mental Hygiene () For State Registrer Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month MAY Day **Physician BOOKER** 18, 2006 2:42p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LAUREL REGIONAL HOSPITAL PRINCE GEORGES COUNTY LAUREL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 TF ARKANSAS OCT. 28, 1918 86 Director 430-32-1629 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other then "natural", or Items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or items 23a or 28a-f show the Wedical Examinar must be notified at Yes 2 No Director PRINCE GEORGES COUNTY LAUREL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14802 ASHFORD PLACE 20707 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify. ğ 3 K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) INSURANCE SECRETARY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be EDITH WHITE UNOBTAINABLE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
sny injury or other trau 1001 TURNEY AVENUE LAUREL MARYLAND 20707 FAYE E. TURNER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/24/2006 LAUREL, MARYLAND MARYLAND NATIONAL CEM. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FLECK FUNERAL HOME 7601 SANDY SPRING ROAD LAUREL MARYLAND 20707 Approximate Interval Between Onset and Death 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIAC ARREST **Physician** 3-4 yrs. /Medical Due to (or as a consequence of) Examiner THIRD DEGREE HEART BLOCK 3-4 yrs. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit SICK SINUS SYNDROME 3-4 yrs. the attending physician and Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760. Physician/Medical DEMENTIA 5+ yrs. use as the IF FEMALE 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? ò Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Ď 99 1 Yes 2 No 3 Probably 4 Unknown Completed DEMENTIA/ALZHEIMERS DISEASE been : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 2 🖾 No 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medicaf examiner? Be 26. Place of Death (Check only one) Hospitaf: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3□ DOA After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Naturat Injury 5 Pending 1 Tes 2 No investigation death 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire i 🖄 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and ty 28003 Comprovocy Creterin who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

9051 MOVIUE D. COLIEGE

FIVIOUSKI

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2006

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Registrar's Signature

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

٠		1- For State Registrar	Certificate of	Death		Reg	No.	000 1045
<ul><li>Physici</li></ul>	an/	Decedent's Name (First, Middle,Last)				Date of Death     Month	Day Year	3. Time of Death
Medical Exami	ner	Kenneth Earl	Bush		to allow (D. all	May 19, 20	06	2019 nrs
		Facility Name (if not institution, give street and number)     Prince George's Hospital Center		Cheverly	Location of Death		4c. County of Prince G	eorge's
Funeral		,	rs. last birthday)	If Under 1 Year Months Day		-	,	Birthplace (State or Foreign
Director		417-98-8096 _{1xm 2-F} 40	Yrs.	Wichtins	s Hours Will.	Sept.4	,1965	Country) Alabama
any		Usual Residence of Decedent         10a. State         10b. County         10c. (	City, Town or Location	on				10d. Inside City Limits
<b>*</b> .*			Capito1	Heigh	te			1 Yes 2 No
Aaryland 28a-f show 1 at once.	횴	Md   Prince Georges   0	Japicoi	10f. Zip Code		100	. Citizen of Wha	
0036 within 72 hours after death with the Maryland jene. her than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once.	Director	506 Clovis Ave.		@0743	}		USA	-
h with	Funeral	11. Marital Status 12. Was Decedent Ever i			spanic Origin? ( Sp n, Mexican, Puerto		14. Race - White,	American Indian, Black,
or ite	핕	1 Yes 2 X N	lo					
rs afte rral",	þ	Wildowed 4 Divorced If Yes, Give Year or Dates:     Decedent's Education (Specify only highest grade completed)		Yes 2 X No	tion (Give kind of w	ork done	Specify: 6b. Kind of Bus	Black
hour "nate	ted	Elementary/Secondary (0-12) College (1-4 or 5+)			DO NOT use retir		Precis	
5-0036 led within 72 hours aft dygiene. other than "natural" the Medical Examina	Completed	12	Wareho	ouse Ma	nager			
5-06 ed wit tygien other	8	17. Father's Name (First, Middle, Last)			18.Mother's Name	(First, Middle, Ma	iden Surname)	
	Be	Noah Bush			-		ooks	
21 nould id Mei is ma	ပို	19a. Informant's Name/Relationship (Type, Print )			et and Number or R			
imore, MD 2121 Pages I and 2 should be fi ment of Heatth and Mental lant: If item 27 is marked or other traumatic event,		Monica Randall-Wife  20a Method of Disposition   2	0b. Place of Disposi					, M.d 2 0 7 4 3 Dity or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite			crematory or oth	er place)				
imor Pages   ment of   tant: If or other		4 Bullation 5 Other Specify.				0/26/06	Annan	dale,Va.
Baltimo permit. Pages Department of Important: I		21. Signature of Funeral Service Licensee	22. N	ame and Addres: ninn Fu	ineral S	Service		22206
	(i) (i)	23a Part I. Enter the disease, or complications that caused the de			2605 S.	Shirli	ngton	Rd.Arl.Va.
Physician /Medical	o 0	failure. List only one cause on each line.				roop and y	r, erroom, or rious	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Atheroscleroti  Due to (or as a consequence)		cular dis	ease		11	Death
1		Sequentially list conditions, b.	20 017.					
	ner	if any, leading to immediate . Due to (or as a consequence cause. Enter Underlying Cause	ce of):					
	Examiner	Cilisease or injury that initiated events resulting in death) Last	ce of):					
ansit of the		d.	,					
760, Cate be executing physician and he burial - train	Physician/Medical	X UNPENDED AMENDED item#2	3a,27,perME	,g856,6/1,	/06 TT			
8760, tificate bung physicas the burner	Mec	IF FEMALE: 23c. If yes, outcome of p	pregnancy				23d Date of d	elivery
687 certific ding	ian/	23b. Was decedent pregnant in the past 12 months?	of doath		Ectopic pregna	ncy	Month	Day Year
Box 68 e death certi	/sic	1 Yes 2 No 9 Unknown	of death 5 Oth	ner (Specify)				
P.O. Box 68 that the death certifued by the attending detached for use as	Ph	Part II. Other significant conditions contributing to death but n	not resulting in the u	nderlying cause	given in Part I.	23e. Did toba	acco use contrib	ute to the cause of death?
res that to signed by the detact	ğ					1 Yes	2 V No 3	Probably 4 Unknown
ds, requir	Completed by					24a. Was an		ere autopsy findings available
COF law 1 shas b e 2 sh	ig I					autopsy	ed? de	or to completion of cause of ath?
tal Re(cian; The certificate		25. Was case referred to medical		26 Place	e of Death (Check o	1 Yes 2	No 1	✓ Yes 2 No
irecto	Be	examiner? Hospital: 4 Innationt 3	✓ ER/Outpatient		Othor:		esidence 6	Other:
Division of Vital Records, tal or Attending Physician: The law requins after death.  al Director: After this certificate has been side in by the funeral director, page 2 should t	<u>د</u>	27. Manner of Death 28a. Date of Injury	28b. Time of Ir	10.23	iry at Work?	28d. Describe ho		
on C ading th.	io	1 Natural 5 Pending (Month, Day, Year)		1	Yes 2 No			
riSic r Atte er dez irecto	ica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - A	<b>!</b> At home, farm, stree	t, factory, office t	ouilding, etc.	28f Location (Str	eet and Number	or Rural Route Number, City
Division pital or Attent ours after death reral Director:	Certification:	Suicide 6 Could not be determined (Specify)				or Town, Sta	te)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier 1 Certifying Physician; To the best of my know						
To the Hos within 24 h To the Fun	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated	on and/or investigati	ion, in my opinior	n, death occurred a	t the time, date ar	id place, and du	e to the cause(s)
F × F ŏ	ğ	29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
×		Margare The Chal		O.C.	M.E.		May 20, 200	6
39,	1	30. Name and address of person who completed cause of death (						
-Qr		Margarita Korell MD. Assistant Medical Exa		enn Street, B	altimore, MD 2	21201		
S Regis	tate	31. Date filed (Menth Pay Year) 2006 37 Registrar's Sig	gnature	ويع				

			1 - For State Registrar	State of	Maryla			nt of H		nd M	iental Hyg	iene	006	16493
	Physic	ian	Decedent's Name (First, Middle,	-, >							2. Date of Dea Month	th Day	Year	3. Time of Death
No.	/Medi	cal	WILLE	Disn				_			MAY	18	Zoile	1056 FM
	Examir	ner	4a. Facility Name (If not institution,	. 1-1-					Location of		•	4c. Co	ounty of Death	
	Funeral		SHOCK TRAUM  5. Social Security Number			. last birthday)		r 1 Year	If Under 2		8. Date of Birth		9 Rinthol	ace (State or Foreign
	<ul><li>Director</li></ul>		214-56-4593	1 🕱 M 2 🗆 F	5	-	Months		Hours	Min.	8. Date of Birth (Month, Day) May 4,	Year) 1949	Count	ace (State of Foreign aryland
	2		Usual Residence of Decedent											
	death with the Maryland rms 23s or 28s-f show f must be notified at	ctor	Maryland 10b. County	N/A	10c. C	ity. Town or Lo	cation	Ва	altimore				10	d. Inside City Limits
	th with th	Funeral Director	10e. Street and Number 807 McKean Avenue				10f. Zi	p Code	2121	7	1	0g. Citize	U.S.A	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "naturel", or Items 23a or 28a-1 show they injury or other traumatic event, the Medical Examinational be notified at ance.	þ	11. Maritaf Slatus  1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	12. Was Deceded Armed Force 1 Tayyes 2 If Yes, Give Year or Date	es? □No		Was Dece If Yes, spe 1  Yes		spanic Origin, Mexican, Specify:	in? (Spe Puerto	ecify Yes or No- Rican, etc.)		Race - America Black, White, e pecify: B	
2-0	72 ho natur	eted	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usu	af Occupa	ition furing most	of work	20	16b. Kind	of Business/Indi	ustry
121	within iene then	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT	ise retired)	auffeur	or workii	ng		Sanitation	Dept.
7	Hygie Hygie ther t		12 17. Father's Name (First, Middle, La	ist)				0110		s Name	(First, Middle, M	Aziden Su	mama)	
Maryland	should be nd Mental marked o	To Be	Willie	R. Bruce		C					Eliza	Peter	rson	
Z	and 2 si ealth an n 27 le r		19a. Informant's Name/Relationshi Mary E. Bruce Wife	s (Typ <del>u</del> , Print)							Route Number, re, Marylan			Code)
Baltimore,	Pages 1 ar		20a. Method of Disposition  1 🖾 Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe			Place of Dispo cemetery, crer	natory or	me of other place	·		os/26/06		ion - City or Tow	
Balti	permit. I Departm Importar eny inju		21. Signature of Funeral Service Li	1	OKe	^	. Name a	nd Addres	s of Facility	uner	al Service, Fitimore, Md	_		
8760, <	Physician and // Medical and physician and physician and the prival transit	dical Examiner	23a. Part. Enter the disease, or by shock, or than failure. List or fmmediate Cause (Finaf disease or condition resulting in death)  Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or influry that initiated events resulting in death) Last	a. Due to (or c. FOL	as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consectin as a consection as a consection as a consection as a consection	quence of): Quence of):	Se Se CTAN	PSIS	fail	ardiac o	r respiratory arre	est,		Approximate milerval Between Onsel and Death  3 WEEKS  3 WEEKS
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Ö	w require been si should t	etec	Moubid Obesity								1 Ye	s 2 <b>X</b> N	o 3 Probat	ofy 4 □Unknown
II Rec		Completed	GENERAL VECO	Nortion	5					_	24a. Was an autopsy perform	ed?	4b. Were autops prior to comp death? 1 \(\sum \) Yes 2	y findings available pletion of cause of 180 No
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=	Physi this o	ို	1 Yes 2 No	Hospital: 1 🕱 fnp:		ER/Outpatien	3 DC	Other	4 🗆 Nurs	ing Hom	ne 5□ Resider	nce 6 🗆	Other (Specify)	
ono	ding f h. After funer	tlon:	27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident investigat		njury Da <i>y</i> Yea <i>r)</i>	28b. Time of fn _f ury	M 2	8c. Injury : Work?	at ? es 2 ⊡ No		8d. Describe how	v injury oc	curred	
Division of Vital Records,	el or Attend s after death il Director: /	Sertification:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Pface of	fnfury - At he etc. (Specif	ome, farm, stre			65 2 110		8f. Location (Str. City or Town,	eet and No State)	umber or Rural F	Route Number,
	To the Hospitel or At within 24 hours after C To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one)  1 X Certifying 2 Medical Ex	Physician: To the be aminer: On the basis and manner	or examina	wledge, death tion and/or inv	occurred	at the time , in my opi	a, date and a nion, death	place, a	nd due to the car d at the lime, da	use(s) and te and pla	I manner as state ce, and due to the	ed. Ne cause(s)
	To ti withii To ti comp	Me	29b. Signature and title of certifier				290	. License	number		29	d. Date si	gned (Month, Da	y, Year)
			Galleunda M	1 Homas	MD		F	719	841			5/10	100	
	2		30. Name and address of person wh	o completed cause of	f death (ften	n 23a) (Type, I	Print)	A		,	12	00	1.	201
(Service)	Sta	te	31. Date filed (Month, Day, Year)		strar's Signa	SHUCK	and	HUMI	4 CER	TEI	R. Ba	V11	more	IVIA
	Registr	ar	MAY 2 3	ZUUU MARA	Section of	0								

State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 Certificate of Death Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death May 21. **Physician** 2006 5:15 P Beatriz Elena Best /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Nursing Home Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or April 23, 1930 Guatemala 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 XX 76 Yrs. 579 90 9757 Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28e-f show any injury or other traumatic event, Ite Medical Evanduations to inclified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's 1 Tyes 2 No Upper Marlboro Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8402 Trumps Hill Road 20772 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home 12th Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pedro de Yurrita Lola Grignard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eddie Best (Husband) 8402 Trumps Hill Road Upper Marlboro, Maryland 20772 20a. Method of Disposition
1 ☑Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July Date 26. Arlington national Cem. 2006 4 ☐ Donation 5 ☐ Other (Specify) Arlington Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735 Down X. Hans MO0257 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebro Vascular Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>Intraventricular Hemorrhage</u> Due to (or as a consequence of) Physician/Medical Examiner signed by the attending physician and do be detached for use as the burial-transit requires that the death certificate be executed Lewybody Dementia Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Autoimmune Hepatitis 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 2 No or Attending Physician: After this certification, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fun 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and Atte of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 51520 May 23, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reater Southeast Hospital Doctors Building # 310 Washignton DC Dr. Pishdad 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2 🕦 🕦 💍 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** May 21 8:55p Won Choe 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie
If Under 1 Year | If Under 24 Hrs. | Mariner Health of North Arundel Anne Arundel 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1₩ 2□F Director 558-77-0696 86 July 30, 1919 Korea Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "naturel", or items 23a or 28a-f ehow edigal Examiner must be notified at 1 Tyes 2 No Maryland Anne Arundel Severn Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1405 Harvey 21144 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after and of Health and Mental Hygiene.
nent of Health and Mental Hygiene.
nent of Item marked other then "naturel; or ite and the treumatic event, the Medical Examinatory or other treumatic event, the Medical Examinatory. 1 ☐ Yes ⊋ ☐ No If Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Asian 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Compi Elementary/Secondary (0-12) College (1-4or 5+) Carpenter 6 Self-Employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kwang Hee Choe Sung R. Won 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sun Ok Kim-daughter 933 Arkblack Terrace, Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or 2002. 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 5/27/2006 Elkridge, MD 22. Name and Address of Facility
Cary L. Kaufman Funeral Home at MMP,
7250 Washington Blvd., Elkridge, MD 21, Signature of Funeral Service Licensee Ma M0123 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (ere brovascular resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physicien: The law requires thet the death certificate be executed ed by the attending physicien and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertenzion 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s hes autopsy performed? certificete 1 ☐ Yes 25 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) ္ 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DQA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation Injury 1 ☑ Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 51596 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 Cakwood Road 103 aby Burne K. Ambalavanar 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

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	/Medic	cal	Augustus  4a. Facility Name (If not institution, gi		Juniou	ıs	4h Cihi	Che	eks Location o	f Dogth	5		2006 County of De		
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	Funeral	6	Social Security Number 6.	Sex 7.	Age (In yrs.	last birthday)	If Unde Months	1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Birt (Month, Da	h ( Year)	9. B	irthplace (State or Foreigr Country)	n
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	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits	
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×	h certifica ending ph use as th	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			]Ectopic p	roananav				2	3d. Date of de	elivery	
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>	W 17	To B	examiner? 1 ☐ Yes 2 ☑ No			ER/Outpatien			4 Nui	rsing Hon	ne 5 🗆 Resid	ence 6	□Other (Sp	ecify)	
_	te line	lon;	27. Manner of Death  1 Natural 5 Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		28c. Injury Work			8d. Describe h	ow injury	occurred		
DIVISION	Attending r death. ector: After by the funer	ertification;	2 Accident investigation 3 Suicide 6 Could not	be 390 Blace of	Injury - At h	ome, farm, str	M eet factor		es 2 🗆 N		8f. Location /S	treet and	Number or F	Rural Route Number,	
	after after din b	ertli	4 Homicide determine		, etc. (Specif			,,			City or Tow	n, State)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one) Certifying F	Physician: To the beaminer: On the basi	is of examina	owledge, death ation and/or in	n occurred vestigation	at the time	e, date and inion, deat	d place, a	nd due to the o	ause(s) a	and manner a place, and du	s stated. e to the cause(s)	
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1	1			completed cause	of death (Iter	m 23a) (Type,	Print) AREST	MT	Rey	<1 F	HE B	in the s	10 2	1217	
	Sta Registr		31. Date filed (Month, Day, Year)	5 2006 32. Reg	Fran's Signa	ature /	4704	2							

06-03380

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Aaron Cole 2006 15497

		Registrar		tificate of De	eatri			3. No.	
Physicia ledical Exami		1. Decedent's Name (First, Middle,La		10016	7		2. Date of Death Month 19	Day Year	3. Time of Death 1259 hrs
out	1161	4a. Facility Name (if not institution, gi	VAKOU AKIN ve street and number)		OLE C	ocation of Death	May <del>18,</del> 20	4c. County of Dea	
		University of Maryland Ho	spital		altimore			N	A
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. Ia		Under 1 Year	If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. E	
Director		213-75-4545 1	M 2 F	Yrs.	lonths Days	Hours Min.	FEB. 1	14.2006 Fore	ountry) <u>MARYLAND</u>
>		Usual Residence of Decedent	Ito ou					7	
w any		10a. State 10b. County	10c. City,	Town or Location	)		0		10d. Inside City Limits  1 Yes 2 No
daryland 28a-f show 3 at once.	후	MARIJLAND 10e, Street and Number	1/A	Lin	DALTI	MORE	CIT	Citizen of What Co	_
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21215-0036 Juld be filed within 77 Mental Hygiene. market other than c event, the Medical	To B	19a. Informant's Name/Relationship (		19b. Mailing Add	ress (Street a	and Number or Ru	ural Route Numb	er, City or Town, Sta	te, Zip Code)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Heath and Mental Hygiers than in: If item 27 is marked other than "natural", or items 23a or 28a-fishen in: If item 27 is narked other than "natural", or items 20a or 28a-fishen other traumatic event, the Medical Examiner must be notified at once		DANI-LLE HUM	PHRIES (MOTHER)	14200	SAMS (	REEK R	B. NEW	WINDSOR	40.
ore, I s 1 and of Healt If item		20a. Method of Disposition  1 X Burial 2 Cremation 3		lace of Disposition rematory or other p		etery,	Dafe .	20c. Location - City of	r Town, State
Baltimore, Definit Pages 1 at Department of Hee Important: If ite		4 Donation 5 Other Specific	Tremoval from State	•	,	NA) 15-	27-06	LANSDOW	WE MARYLAND
Baltimo permit Pag Department Important: injury or of		21. Signature of Funeral Service Lice		22. Name	and ordress of	f Facility B	ONINA	JR. FUNE	RAL HOME
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Physician /Medical		23a. Part I. Enter the disease, or comfailure. List only one cause on e	plications that caused the death, each line. <b>Combined (Ps</b>	Do not enter the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manager than the manage	ode of dying, su doxlam	uch as cardiac or ine. and	respiratory arrès	st, shock, or heart	Approximate Interval Between Onset and
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J.	_	. 1	an		O.C.M.			May 19, 2006	, = 27, 10017
Nh		30. Name and address of person who		23a)		_			
1800				Penn Street, B	altimore, M	ID 21201			
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State of Maryland / Department of Health and Mental Hygiene 🖺 🗎 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** May 10, 2006 Electria Carlucci 5:30AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hill Haven Nursing Home Adlephi Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 31,1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Months Country) PA 1 □ M 2 □XF Hours Yrs. 217-36-5056 Director Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylani Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "naturel", or items 23s or 28s-1 show any njury or other treumatic event, the Medical Examinat must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 HO Maryland Prince George's District Heights Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6600 Burgess Place U.S.A. 20747 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. ☐Yes 2☐No f Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 🖫 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry National Relations Elementary/Secondary (0-12) College (1-4or 5+) Labor Board 12th Supervisor Clerk Typist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ralph Groft Cora Cripes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jordan Luke (Executor) 3063 North Pollard Street Arlington, VA 22207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May Day 6. 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 2006 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6633 Old Alexandria Ferry Road Clinton, MD 20735 100 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sicien and burial-transit certificate be executed Due to (or as a consequence of) attending physicien for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) igned by the a be detached f ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 No 1 Yes 2 🕅 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No 3□ DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospitel or Attending Injury 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5238 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robyn Anderson, Suit 205 LOCKWOOD DELVES 31. Date filed (Month, Day, Year) 32 Registrar's Signature MAY 2 5 2006 Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible I State Plaryland / Department of Health and Men. Hygiene

		1- For State Registrar		Cer	tificate of	Deam		Re	g. No	juo nous
Physici ical Exam		Decedent's Name (First, Michael Ruth Ann Duck				* ****		2. Date of Death Month May 18, 20	n Day Year	3. Time of Death 2348 hrs
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Funeral Director		5. Social Security Number 193–48–0540	6. Sex	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min	_	,	9 Birthplace (State or Foreign Country) PA
permit Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number 955 Forest Dr  11. Marital Status 1 Never Married 2	Arundel  ive    12. Was Dec     Armed F     1	Arno.  Redent Ever in U.  Proces?  2 X No or de completed)	S. 13. Was If Ye 1 — 16a. Decedent during mo	21012 Decedent of Hisps, specify Cuban, I  Yes 2 X No 's Usual Occupations of working life. E	anic Origin? (Sp. Mexican, Puerto specify: In (Give kind of v O NOT use reti Mother's Name Elizabe and Number or F	pecify Yes or No- Rican, etc.)  work done red)  e (First, Middle, M  e Th Manr  Rural Route Numb	g. Citizen of Wha  US  14. Race White, Specify: 16b. Kind of Bus  Lumber aiden Surname) 1 per, City or Town	10d. Inside City Limits 1 Yes 2 X No it Country?  A American Indian, Black, etc.  White ness/Industry  Industry  State, Zip Code)
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		1 - State Registrar	·	Certificate of Death		Reg. No.	10000		
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Funeral			Sex 7. Age (In yrs. last 1 ☐ M 2 🖫 F	birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Bir (Month, Da	th ly, Year) 9. Birth Cou	place (State or Foreigntry)		
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